00681

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore,
City or town: Towson,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore-
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Presbyterian Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Katherine Virginia Abendschein

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Harry
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 18, 1868

8. AGE: Years: 79 | Months: 3 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER
12. Name: Henry Smith Sohl
13. Birthplace: Va.

MOTHER
14. Maiden name: Martha P. Durham
15. Birthplace: Md.

16. Informant: Records - Presbyterian Home
Address: Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/26/47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Fred. Ave. Balto. Md.

18. Funeral director: John O'Mitchell Sons Inc.
Address: 1900 Eutaw Place

19. Apr. 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1947, at 10.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947, to April 23 1947
and that I last saw her alive on April 23, 1947

Immediate cause of death	DURATION
apoplexy —	2 hrs.
Due to: arteriosclerosis +	
Due to: hypertension	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Hunt Green M.D.
M. D. or other
Address: Towson Md. Date signed 4/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

00683

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
605 Dunkirk Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 605 Dunkirk Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MARGARET R. ALBERT

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John V. Albert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 3, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	18	..... hrs. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name - Ehrman
13. Birthplace Balto., Md.

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mr. Milton A. Albert
Address 605 Dunkirk Rd. Balto 12

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/24/47 (month) (day) (year)
Cemetery or crematory Parkwood Cem.
Location Balto., Md.
18. Funeral director Wm J Tuckner & Sons
Address North & Penn Aves.
19. 4/22 1947 A W. Hedrick D Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1947, at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1947, to April 21 1947
and that I last saw h R alive on April 21 1947

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Laurence C. Tooth M. D. or other
Address 6805 York Rd Date signed 4/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00683 B

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Mrs. Louise E. Arrington

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Benjamin F. Arrington
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) February 11 - 1857

8. AGE: Years	Months	Days	If less than one day
90	2	—	... hrs. ... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER	12. Name	Cornwell
	13. Birthplace	Virginia
MOTHER	14. Maiden name	Unknown
	15. Birthplace	Virginia

16. Informant Albert M. Arrington
Address Brooklandville P.O., Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14-1947 (month) (day) (year)
Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland
18. Funeral director Burgee Funeral Home
Address 3631 Falls Road
19. April 14 1947 A.W. Hebeck Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11- 1947, at 11 45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1945 to April 11th 1947
and that I last saw h.. alive on April 11th 1947
Immediate cause of death Acute Cardiac Dilation — DURATION
Due to Malignancy of Uterus and Rectum — 18 Mo.
Due to Acute Cardiac Hypertrophy.
Due to Senile Atty. Etc.
Other conditions —
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. ...
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE B. S. Lillian M. D. or other
Address 3614 Falls Rd. Balto. Date signed 4/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

00684

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Maryland Line
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Maryland Line
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Inez Atkinson.

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow.
6.(b) Name of husband or wife: Hiram Atkinson.
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): May 20, 1855.
8. AGE: Years: 91 Months: 10 Days: 29 If less than one day: hrs. min.
9. Birthplace: Frederick, Md.
(Town, county, and state)
10. Usual occupation: Retired.
11. Industry or business: Housekeeper
FATHER 12. Name: James Thomas Heathcote
13. Birthplace: England.
MOTHER 14. Maiden name: Mary Eliz. Whitaker.
15. Birthplace: Unknown.
16. Informant: Mrs. Inez Johnson
Address: Maryland Line Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2 1947 (month) (day) (year)
Cemetery or crematory: Louden Park Cemetery.
Location: Frederick Ave. Baltimore Md.
18. Funeral director: Jacob Hardenbergh
Address: New Freedom, Pa.
19. April 21 1947 (Date rec'd by registrar) Roberta L. Fuchs Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1947; at 1:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1947, to April 19 1947
and that I last saw h.er alive on April 11th 1947
Immediate cause of death: Chronic myocarditis

	DURATION
Due to	
Due to: Accidental fall. Tripped over rug, and fell. Sust.	
Other conditions: Fracture of neck of left & right femur.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of: January 11th, 1947.
Where did injury occur? Maryland Line (City or town) Baltimore (County) Maryland (State)
Injured at home, farm, industry, public place (where?): At home.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: G. W. France M. D. or other
Address: Parkton, Md. Date signed: 4/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
APR 29 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

00685

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
6301 Liberty Heights Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6301 Liberty Heights Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Genevieve Elizabeth Barker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Hugh Joseph Barker
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1886

8. AGE:	Years	Months	Days	If less than one day
	60	9	8	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home

FATHER
12. Name George H. Pryor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Emma Busick
15. Birthplace Baltimore, Md.

16. Informant Mrs. Ruth Barker
Address 6301 Liberty Heights Ave., Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19,1947 (month) (day) (year)
Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18. Funeral director Miller Lamborn
Address 4510 Liberty Heights Ave.

19. April 18 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1946, to April 16 1947
and that I last saw her alive on April 14 1947

Immediate cause of death	DURATION
(a) Primary Carcinoma of Colon	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations - Carcinoma of Colon Date of op.
Autopsy results - None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Earl L. Hamburger M.D.
M. D. or other
Address 4108 Liberty Heights Ave. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

06686 B

CERTIFICATE OF DEATH

Reg. Dist. No. 20 1

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 months 26 days

Hospital, Institution, or street address where death occurred:

Spring Grove St. Hosp.

How long in hospital or institution? 1 month 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore City Hospital

(If outside city or town limits, write RURAL and give nearest town)

Street No. 625 W Fayette St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ANNA BARKUS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	W	widowed

6.(b) Name of husband or wife Joseph

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE:

Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace Lithuanian (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER

12. Name Joseph BARKUS

13. Birthplace Lithuanian

MOTHER

14. Maiden name ONIE CICERKOVSKA

15. Birthplace Lithuanian

16. Informant Hospital records

Address Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21 - 47 (month) (day) (year)

Cemetery or crematory Holy Redeemer Cem

Location Belair Rd

18. Funeral director Joseph Kasemskas Inc

Address 602 Washington Blvd

19. 4/19 19 47 J. C. Hedrick DM Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 47 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 28 19 47 to April 17 19 47

and that I last saw her alive on April 17 19 47

	DURATION
Immediate cause of death: cardiac failure	12 hrs
Due to: Bronchio Pneumonia Lobar	10 days
Due to:	
Other conditions: general arteriosclerosis, chronic myocardial disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gordon Hurd M. D. or other

Address Spring Grove Date signed 4.17.47

VS A15 9-45 5M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00687

1312

Reg. Dist. No. 37

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Simona Ave (Rural)
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William Franklin Barnett

3.(b) Social Security Number: 216-07-3888

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Amelia (Wilhelm)

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	18	...hrs. ...min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Machinists helper

11. Industry or business: Black & Decker Mfg. Co.

FATHER
12. Name: George Barnett
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Martha Ellen Marlin
15. Birthplace: Balto. Co, Md.

16. Informant: Mrs. W. F. Barnett
Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 7, 1947 (month) (day) (year)

Cemetery or crematory: Poplar Church

Location: Cockeysville, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 4-5- 1947 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 7 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to 4/4 1947

and that I last saw h... alive on 4/5 1947

	DURATION
Immediate cause of death: Empyoearditis	2 yrs.
Due to: Chronic Suppuritis	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Wilmer C. Ensor M. D.
M. D. or other

Address: Cockeysville Md. Date signed 4/5/47

00688 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs 8 mos 4 da
Hospital, institution, or street address where death occurred:
Rosewood State Training School Owings Mills
How long in hospital or institution? 13 yrs 8 mos 4 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1014 S. Paca St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Daniel Bauer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1926

8. AGE:

Years	Months	Days	If less than one day
21	1	5	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Inmate; Rosewood State Training School; Owings Mills, Md.
11. Industry or business:

FATHER
12. Name: Robert Stanton Bauer
13. Birthplace: Baltimore City

MOTHER
14. Maiden name: Susie Petri
15. Birthplace: Baltimore City

16. Informant: Institutional Records, Rosewood
Address: State Training School; Owings Mills, Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 4/24/47 (month) (day) (year)
Cemetery or ~~crematory~~: London Park
Location: Balto., Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. 4/22 1947 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 1947 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 1933 to April 21 1947 and that I last saw h-- alive on April 21 1947

Immediate cause of death	DURATION
Status Epilepticus	1 da
Due to:	
Due to: Lead-	
Other conditions: Post-Encephalitic, Epileptic Idiot.	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) None (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C. Mediary M. D.
M. D. or other
Address: Owings Mills, Md Date signed: 4/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00689

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 6 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 years, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 924 Druid Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: WILLIAM BASCH

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	widowed

6.(b) Name of husband or wife: Jennie ?
6.(c) If alive, give age: –

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE:	Years	Months	Days	If less than one day
	56			...hrs. ...min.

9. Birthplace: Pltosk, Poland (Town, county, and state)
10. Usual occupation: cabinet maker
11. Industry or business: cabinet making

FATHER
12. Name: Noel Joseph Basch
13. Birthplace: Poland

MOTHER
14. Maiden name: Rachel Krantz
15. Birthplace: Poland

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 4/15/47 (month) (day) (year)
Cemetery or crematory: Helen Herring Run
Location: Boundary Lane
18. Funeral director: Sol Levinson Bros
Address 1124 W Pratt ave

19. 4-14-1947 (Date rec'd by registrar) Harry W. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 19 47, at 10:55p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 44, to April 12 19 47
and that I last saw h...im...alive on April 12 19 47

Immediate cause of death	DURATION
Chronic myocarditis, chronic	
interstitial nephritis.	Indef.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
Isadore Tuerk
Address: Catonsville 28, Md. M. D. or other
Date signed: 4/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

00690

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 48 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 733 Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: JAMES A. BEARD, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: - -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-19-19

8. AGE: Years	Months	Days	If less than one day
28	1	10	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

FATHER
12. Name: James A. Beard
13. Birthplace: Highland County, Va.

MOTHER
14. Maiden name: Fannie Hamilton
15. Birthplace: Craigsville, Va.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1947 (month) (day) (year)
Cemetery or crematory: Craigsville, Virginia
Location: Craigsville, Virginia

18. Funeral director: Charles R. Law
Address: 802 Madison Avenue, Balto. Md.

19. May 1 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1947 at 4:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1947 to April 29 1947 and that I last saw him alive on April 29 1947

Immediate cause of death	DURATION
HOMICIDE: GUNSHOT WOUND OF LEFT CHEST: TRANSVERSE SECTION OF SPINAL CORD WITH PARALYSIS	4 months
Due to:	
Due to:	
Other conditions: WASTING, DECUBITUS ULCERS, URINARY TRACT INFECTION. (Include pregnancy within 3 months of death)	6 weeks

Major findings of operations: Suprapubic Cystotomy
Date of op.:
Autopsy results: SUBSTANTIATED ABOVE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 12/25/46
Where did injury occur? Turner's Station, Dundalk, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): See above.
Means of injury: 38 Caliber Pistol Injured at work? No.

23. SIGNATURE: R. B. Davis, M.D. (M.D. or other)
Address: Dept. Med. Examiner Date signed: 4/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

00691 41

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Balto

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7008 Dunman Way

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Lester Dealton Bedell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Clara L Bedell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 28 1880

8. AGE: Years	Months	Days	If less than one day
66	21	14	..... hrs. ..... min.

9. Birthplace Jewell New York (Town, county, and state)

10. Usual occupation Electrical Engineer

11. Industry or business

FATHER 12. Name John H Bedell

13. Birthplace N Y

MOTHER 14. Maiden name Angeline Blumgarner

15. Birthplace N Y

16. Informant Mrs Clara Bedell

Address 7008 Dunman Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1947 (month) (day) (year)

Cemetery or crematory Meadow Ridge

Location Dorsey Md

18. Funeral director Ulrich Funeral Home

Address 2008 Orleans St

19. 4-14-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Coronary Occlusion	
Due to (b) A.S.C.V.D. Disease	Yrs.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE M Bowers M.D.

With. Funl. Director Bl. Mortuary Co.

Address Dundalk Md Date signed 4-14-47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00692 B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124

CERTIFICATE OF DEATH

Reg. Dist. No. 44

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Willow Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME

MELVIN H. BENNETT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~////~~ Irene Bennett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8-28-06

8. AGE:

Years	Months	Days	If less than one day
40	7	23	..... hrs. ..... min.

9. Birthplace: Harrisonburg, Va.

(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER

12. Name: William Bennett

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/47 (month) (day) (year)

Cemetery or crematory: Canaan Methodist Epis.

Location: Waynart, Pa.

18. Funeral director: John A. Adam

Address: 4201 Greenmount ave.

19. 4/22 19 47 A.W. Hedrick 2nd Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1947 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1947 to April 21, 1947 and that I last saw him alive on April 21, 1947

Immediate cause of death	DURATION
Fatty change in liver with enlargement	Unknown
Due to History of vitamin deficiency and chronic alcoholism for 3 weeks and ~~xxx~~ 8 Months respectively	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. Dir. M. D. or other

Address V.A.H. FORT HOWARD, MD. Date signed 3-21-47

Dr. M. Green
Evergreen Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 58952
U0693

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3042 Woodside Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3042 Woodside Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha O. Benson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Maurice G. Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1889

8. AGE: Years	Months	Days	If less than one day
57	11	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Maurice G. Benson
(b) Address 3042 Woodside Avenue

17 (a) Burial (b) Date thereof 4/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 22 1947 (b) Lustington for Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947, at 9 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 19 1947 and that I last saw h[illegible] alive on April 19 1947.

Immediate cause of death Cerebral Hemorrhage (Apoplexy) — Duration Apr 15
Due to
Due to
Other Conditions Arterio Sclerosis — a number of years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Baltimore 14 md. Date signed 4/21/47

V S 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

8

00694 42

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town Td Dewold
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore Co
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6508 Bamberg Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John C Berg

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mildred A (Miller)
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1889

8. AGE: Years 57 | Months 7 | Days 11 | If less than one day hrs. min.

9. Birthplace Brooklyn New York
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Wm C Scheer + Co

FATHER
12. Name John C Berg
13. Birthplace Sweden

MOTHER
14. Maiden name Anderson
15. Birthplace Sweden

16. Informant Mrs Mildred A Berg
Address 6508 Bamberg Rd

17. Burial
(Burial, cremation, or removal. Which?) Date thereof April 19 1947
(month) (day) (year)
Cemetery or crematory Balto. National
Location 5501 Frederick Ave

18. Funeral director Harry H Witzke
Address 4101 Edmondson Ave

19. 4-18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1946 to April 16 1947
and that I last saw him alive on April 16, 1947
Immediate cause of death Carcinoma of Stomach — DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Laurence B Wolfe M.D.
M. D. or other
Address 1331 S Eutaw St Date signed 4-17-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(83a)

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Hoods Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Hoods Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sister Mary Charlotte Bishop

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1874

8. AGE: Years	Months	Days	If less than one day
73	2	9	..... hrs. ..... min.

9. Birthplace Rochester N.Y. (Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER 12. Name Nathan Bishop

13. Birthplace New York

MOTHER 14. Maiden name Mary Hummel

15. Birthplace Rochester

16. Informant Sr. Mary Clara

Address Hoods Cliff

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 9/47 (month) (day) (year)

Cemetery or crematory Hoods Cliff

Location Towson

18. Funeral director Geo. M. Fuith & Son

Address Govanstown

4/8/47 (Date rec'd by registrar) 19 W. D. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 47 at 4.20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 19 43, to April 7 19 47

and that I last saw her alive on April 2 19 47

	DURATION
Immediate cause of death: Apoplexy	Since March 13/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. Green M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00696

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Balto.
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
2624 Hillcrest Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2624 Hillcrest Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MARIE E. BOHNE

3.(b) Social Security Number
NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife John L. Bohne
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1887

8. AGE:

Years	Months	Days	If less than one day
60	2	21	..... hrs. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr. John L. Bohne,
Address 2624 Hillcrest Ave., Balto. 14, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Apr. 8, 1947 (month) (day) (year)
Cemetery or crematory Baltimore
Location Balto., Md.

18. Funeral director Lasenby Funeral Home
Address 7401 Belair Road

19. 4/5 1947 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th, 1947 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947 to April 5 1947 and that I last saw h.. alive on April 4 1947

	DURATION
Immediate cause of death: Acute cardiac failure	2 days
Due to: Influenza	1 week
Due to:	
Other conditions: Myotonia atrophica	10 years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. M. Bacon M. D. or other
Address 2510 Taylor Ave. Date signed 4/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

Reg. Diat. No. 30

00697 P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 month, 22 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 year, 1 month, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 724 West Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: NO

3.(a) FULL NAME: Margaret Boone

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white---	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 9, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	1	hrs. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: William C. Boone
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes B. Morrisey
15. Birthplace: Canada

16. Informant: Hospital records
Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/12/47 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Balto. Md.

18. Funeral director: William Cook Inc.
Address: 12-17 St. Paul St.

19. 4/11 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 19 47 at 8:17 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 19 46 to April 10 19 47 and that I last saw her alive on April 10 19 47

	DURATION
Immediate cause of death: Pneumonia, lobar?	24 hrs.
Due to: Arteriosclerotic cardiovascular disease --	indefinite
Due to:	
Other conditions: Fracture of right femur (3-28-47)	13 days

(Include pregnancy within 3 months of death)

Major findings of operations: 4-11-47 Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 3-28-47

Where did injury occur? Main Building, South Wing (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Spring Grove State Hospital

Means of injury: Fall Injured at work? --

23. SIGNATURE: Isadore Tuerk, M. D. (M. D. or other)

Address: Catonsville-28, Md. Date signed: 4-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

U0698

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
County
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years, 11 months, 1 day
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 6 years, 11 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 239 N. Fulton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: MARIE E. BORNEMANN

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1868

8. AGE: Years	Months	Days	If less than one day
78	8	13	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: seamstress
11. Industry or business: sewing

FATHER
12. Name: August Bornemann
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Germany

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 14-47 (month) (day) (year)
Cemetery or crematory: Goodwill
Location: Rutledge, Harford Co. Md.
18. Funeral director: Martin E. Kurtz
Address: Jarrettsville Md.

19. 4-13-1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 19 47 at 8:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 19 40 to April 12 19 47 and that I last saw her alive on April 12 19 47

	DURATION
Immediate cause of death: (a) Bronchopneumonia	7 days
Due to: (b) Myocarditis chronic	Indef
Due to: (c) Generalized A.S. disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Isadore Tuerk
Catonsville 28, Md.
M. D. or other
Address Date signed 4/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-C)

CERTIFICATE OF DEATH

06699

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 Broadship Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George M. Boynton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mabelle Benham
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 19, 1872

8. AGE:

Years	Months	Days	If less than one day
75	3	7	hrs. min.

9. Birthplace: McLean, N. Y.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: George H. Boynton
13. Birthplace: N. Y.

MOTHER
14. Maiden name: Frances Crittenden
15. Birthplace: N. Y.

16. Informant: Mrs. Mabelle Boynton
Address: 12 Broadship Road, Dundalk

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 27 1947 (month) (day) (year)
Cemetery or crematory
Location: Ithaca, New York.

18. Funeral director: Roland L. Fisher
Address: 2112 Dundalk Ave.

19. 4/27/47 (Date rec'd by registrar) J. M. Barnum Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 - 1947, at 6:20 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 1946, to April 26 1947, and that I last saw h[illegible] alive on Thurs. 1947.

Immediate cause of death	DURATION
Coronary Occlusion	5 Min
Due to: A-S-C-V-Renal Disease	18 Mos.
Due to:	
Other conditions: 1. Ca. of Bladder	—
2. Hypertrophy of Prostate	—

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M B Davis M.D.
M. D. or other
Address: Dundalk-Rt-No. 1 Date signed: 4/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

00700

Reg. Diat. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1264 Voet Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lawrence Edgar Browning

3. (b) Social Security Number: 216-05-1461

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ina Browning
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12/14/1899

8. AGE:

Years	Months	Days	If less than one day
47	3	23	— hrs. — min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: Davis Rex Co. - Rud.
FATHER 12. Name: Luther L. Browning
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Ida S. Barton
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Ina Browning
Address: 1264 Voet Ave Arbutus
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 9-47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
16. Funeral director: F. O. Stikbert & Son
Address: 1300 Eutaw Pl-17
19. April 8 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6th 19 47, at 11:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4th 19 47, to April 6 19 47
and that I last saw him alive on April 4 19 47

Immediate cause of death	DURATION
Cardiac failure	
Due to: Toxemia	
Due to: Carcinoma Breast	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma Date of op. 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. W. Kieffer M. D. or other
Address: 2470 Park Blvd Date signed: 4-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136

00704

CERTIFICATE OF DEATH

Reg. Dist. No. ____

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since October 7, 1946

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since October 7, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

Street No. 417 Fountain St (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Marguerite Bullock

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard M Bullock

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 14, 1917

8. AGE: Years: 34 | Months: 10 | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Havre de Grace Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Grace Chrashus

FATHER — 13. Birthplace: Havre de Grace Md

MOTHER — 14. Maiden name: Nellie Clark

MOTHER — 15. Birthplace: Havre de Grace Md

16. Informant: Personal History-Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-18-47 (month) (day) (year)

Cemetery or crematory: Angel Hill Cem.

Location: Havre de Grace Md

18. Funeral director: Pennington & Son

Address: Havre de Grace Md

19. April 16 1947 (Date rec'd by registrar) C. W. Herbert Registrar

85

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1947, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1946, to April 15 1947 and that I last saw h[illegible] alive on April 15 1947

	DURATION
Immediate cause of death: Air embolism	Instantaneous
Due to:	
Due to:	
Other conditions: Pulmonary tuberculosis, Cavity June 1946 (Include pregnancy within 3 months of death)	

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: C. A. Bridges M. D. or other

Address: Towson 4, Maryland Date signed 4-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 1-9-47-15M

BALTIMORE CITY HEALTH DEPARTMENT 123

CERTIFICATE OF DEATH

Registered No. 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 Thursh St. Dundalk, Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Thursh Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA MAY CARRINGTON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1945

8. AGE: Years	Months	Days	If less than one day
2			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Marion Carrington
15. Birthplace Keysville Virginia

16 (a) Informant Mary Pryor
(b) Address 639 Threcal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave

19 (a) May 2 1947 (Date rec'd by registrar) (b) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947, at 6.10 a M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute mesenteric adenitis

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 4-30-47

VS 151

VS A15 9-46 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1220)

CERTIFICATE OF DEATH

06703

Reg. Dist. No. 3-D

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years 4 months 3 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 12 years 4 months 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Jesse May Chamberlain

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Leon Chamberlain

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): Nov. 11 1871

8. AGE: Years	Months	Days	If less than one day
75 ~~76~~	5	4	....hrs. ....min.

9. Birthplace: Massachussetts (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: Theodore W. Draper

13. Birthplace: Mass.

MOTHER

14. Maiden name: Adelaise H. May

15. Birthplace: Mass.

16. Informant: Hospital Records

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-47 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Annapolis Md

18. Funeral director: E Willis Lamoreux

Address: 1003 W. Baltimore St.

19. 4-29 1947 (Date rec'd by registrar) Harris Hayworth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1947 19.... at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12, 1934 19.... to April 15 1947 and that I last saw her alive on April 15, 1947 19....

Immediate cause of death	DURATION
Strangulated hernia - ventral - purulent peritonitis	20 hrs.
Due to: Chronic myocarditis	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 4/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 75M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93e

CERTIFICATE OF DEATH

00704 Reg. Dist. No. 44

1. PLACE OF DEATH:
County BALTIMORE
City or town FORT HOWARD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 days
Hospital, Institution, or street address where death occurred:
VAH FORT HOWARD, MARYLAND
How long in hospital or institution? 65 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3509 HAYWOOD AVENUE BALTIMORE, 15, MD.
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3.(a) FULL NAME CLARK, Abraham N.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife //// May Clark
6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1899

8. AGE:

Years	Months	Days	If less than one day
57	5	10	..... hrs. ..... min.

9. Birthplace PORTLAND, MARYLAND (Town, county, and state)

10. Usual occupation GAS & ELECTRIC INSTRUCTOR

11. Industry or business

FATHER
12. Name SAMUEL CLARK
13. Birthplace MARYLAND

MOTHER
14. Maiden name ELIZABETH HANDS
15. Birthplace MARYLAND

16. Informant CLINICAL RECORDS, VETS. ADM. HOSP.
Address FORT HOWARD, MARYLAND

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof May 3, 1947 (month) (day) (year)
Cemetery or crematory PRIVATE CEMETARY DRUID RIDGE
Location BALTIMORE, MARYLAND

18. Funeral director LORING BYERS
Address BALTIMORE, MARYLAND

19. May 1 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 29 1947 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 23 1947 to APRIL 29 1947 and that I last saw him alive on APRIL 29 1947

Immediate cause of death	DURATION
DISEASE OF THE HEART:	
CAUSE: CORONARY ARTERIOSCLEROSIS	65
Due to STRUCT. LES: HYPERTROPHY OF MYOCARDIUM	days plus
Due to MANIFESTATIONS: MYOCARDIAL FAILURE	
Due to CAUSE:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR. M. D. or other
Address V.A.H. FORT HOWARD, MD. Date signed 4/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00705 P

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 436 days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 436

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 907 E. 23 St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILLIE COOK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Annie Cook

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 1-13-1892

8. AGE: Years 55 Months 2 Days 22 If less than one day ... hrs. ... min.

9. Birthplace Petersburg, Virginia (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name James Cook

13. Birthplace Virginia

MOTHER 14. Maiden name Mariah Stewart

15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 9 43 (month) (day) (year)

Cemetery or crematory Balto Nat Cem

Location Baltimore Md

18. Funeral director William A. Jackson

Address 916 Pennsylvania Avenue, Balto, 1, Md.

19. 4/8 1947 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947 at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 1946 to April 5 1947 and that I last saw him alive on April 5 1947

	DURATION
Immediate cause of death COronary occlusion, acute, sudden	
Due to coronary arteriosclerotic heart disease	4 months
Due to	plus
Other conditions Tuberculosis, pulmonary, chronic, probably arrested. (Include pregnancy within 3 months of death)	15 months plus

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L M Cullison

R.M. CULLISON, M.D. CLIN. DIRECTOR

Address VAH, FORT HOWARD, MD. Date signed 4/6/47

Coroner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00706 P

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore, Maryland
City or town: Ft. Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 days
Hospital, institution, or street address where death occurred:
VAH, Ft. Howard Maryland
How long in hospital or institution? 46 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1030 W. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME: CORNELIUS, GEORGE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mrs. Laulein Cornelius
Cleveland, Ohio 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Macon, Georgia 5/2/ 1900

8. AGE: Years	Months	Days	If less than one day
46	11	4	____ hrs. ____ min.

9. Birthplace: Macon, Georgia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Louis Cornelius
13. Birthplace: Georgia

MOTHER
14. Maiden name: Hilda Hill
15. Birthplace: Unknown

16. Informant: Clinicial Records, Vets, Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-47 (month) (day) (year)
Cemetery or crematory: Balto Meml
Location: Balto Md.

18. Funeral director: Charles H Cooper
Address: 510-12 Cancelton Bldg.

19. 4/10 19 47 A.K. Kedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 19 47, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19, 19 47, to April 6, 19 47 and that I last saw h[illegible] alive on April 6, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIR. M.D. or Other
Address: V.A.H. FT. HOWARD, MD. Date signed: 4-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

00707

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Balto.
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3522 Forest Hill Rd.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3522 Forest Hill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SOPHIA CROUSE

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Michael J. Crouse
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	22	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name ? Lente
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany

16. Informant Mrs. Estella F. Smith
Address 3522 Forest Hill Rd., Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/5/47 (month) (day) (year)
Cemetery or crematory St. Peters Cem.
Location Balto. Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. May 7 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1947, to April 30 1947
and that I last saw her alive on April 30 1947

Immediate cause of death	DURATION
Acute Dilatation of Heart	7 days
Due to Myocarditis	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. C. Smith M. D. or other
Address 4502 Liberty Hgts. Date signed May 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-46M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

06708

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County Baltimore

City or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Margaret Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles F. Dedio

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Dedio

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 - 1866

8. AGE: Years	Months	Days	If less than one day
80	9	9	hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business

MOTHER FATHER

12. Name Peter Dedio

13. Birthplace Germany

MOTHER

14. Maiden name Francis Weigert

15. Birthplace Not Known

16. Informant Emma Dedio

Address 14 Margaret Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8-47 (month) (day) (year)

Cemetery or crematory Bal Lawn Cemetery

Location Eastern Ave.

18. Funeral director John A. Miller

Address 2334 Jefferson St.

19. 4-7 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 47, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 47 to April 7 19 47 and that I last saw h alive on April 7 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardio-Vascular disease	
Due to	
Other conditions Arteriosclerotic Gangrene L. Wk. left foot.	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo M. Baumgardner M.D.
M. D. or other

Address Balto 6 Md Date signed 4-5-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

00709

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Eccleston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Eccleston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Maurice Eugene Dixon Sr.

3.(b) Social Security Number: 216-07-1895

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith R. Dixon
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1895

8. AGE: Years	Months	Days	If less than one day
51	11		hrs. min.

9. Birthplace: Penna. (Town, county, and state)
10. Usual occupation: Black & Decker Plant
11. Industry or business

FATHER
12. Name: Wm. T. Dixon
13. Birthplace: Frederick Co.

MOTHER
14. Maiden name: Salome E. Sechrist
15. Birthplace: Penna.

16. Informant: Edith R. Dixon
Address: Lutherville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. April 20 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 April 1947, at 4:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Feb 47 1947 to 18 April 1947
and that I last saw h.i.v.m. alive on 18 April 1947

Immediate cause of death	DURATION
Carcinoma Stomach with Metastasis to Liver	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Huge Carcinoma Antrum Stomach with metastasis to Liver & Cul-de-Sac. Date of op. 8 Mar 47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. F. Ermeler, MD
M. D. or other
Address: Reisterstown, Md. Date signed: 19 April 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


APR 22 1947
BOREAD

STATE OF MARYLAND—CERTIFICATE OF DEATH

124b 00710 P

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 38

Village or City Towson No. 121 W. Susquehanna Ave. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Martin Joseph Donahue

(a) Residence: No. 121 W. Susquehanna St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Anna

6. DATE OF BIRTH (month, day, and year) March 18, 1904

7. AGE	Yeers	Months	Days	If LESS then 1 day, ... hrs. or ... min.
	43	1	4	

OCCUPATION

8. Trade, profession, or perticuler kind of work done, as SPINNER, SAWYER, BDDKKEEPER, etc. Service Mgr.

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc. H. A. Harris Co.

10. Dete deceesed last worked at this occupation (month and year) ...

11. Total time (yeers) spent in this occupation ...

12. BIRTHPLACE (city or town) Glen Gunn (State or country) Md.

FATHER

13. NAME Michael Joseph Donahue

14. BIRTHPLACE (city or town) Ireland (State or country)

MOTHER

15. MAIDEN NAME Anna G. Breidenbaugh

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFDRMANT Mrs. Rose A. Donahue (Address) 121 W. Susquehanna Ave

18. BURIAL, CREMATIDN, DR REMDVAL Place Long Green Cem. Date 4-25, 1947

19. UNDERTAKER Leonard J. Rush (Address) 5305 Harford Rd

20. FILED April 24 19 47 A. M. Hearick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 22 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1947, to Apr 22, 1947

I last saw h... liv... alive on 22 Apr, 1947; deeth is said to have occurred on the date steted above, at 9 A. m.

The PRINCIPAL CAUSE OF DEATH and related ceuses of Importence were es follows:

	Date of onset
Hemorrhage from Oesphageal Varicies	22 Apr 47
Dther Contributory Causes of Importance: Cirrhosis of Liver	1946

Neme of operation None Date of ...

Whet test confirmed diagnosis? Clinical Wes there en eutopsy? No

23. If death was due to external causes (VIDLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether Injury occurred In INDUSTRY, In HDME, or In PUBLIC PLACE.

Manner of injury ...

Neture of injury ...

24. Wes diseese or injury in eny way releted to occupetion of deceesed? No

If so, specify ...

(Signed) Charles H. Keier M. D.

(Address) 6701 York Rd Balto 12 Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(932) 00711

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Balto Co

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred: 540 South Rolling Road

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 540 Rolling Rd

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Frances E Downes

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Francis Downes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 4 1870

8. AGE:

Years	Months	Days	If less than one day
76	8	2	..... hrs. ..... min.

9. Birthplace: Washington D C (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: House work

FATHER

12. Name: Thompson R East

13. Birthplace: Maine

MOTHER

14. Maiden name: Harriet N Duvall

15. Birthplace: Virginia

16. Informant: Mrs J Fox

Address: 540 South Rolling Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore City Md

18. Funeral director: Chas S Mad Hatter

Address: Catonsville Md

19. 4-5-47 (Date rec'd by registrar) Harry J Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947 at 8a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION .....

Due to: .....

Due to: Cardio vascular disease .....

Other conditions: Sudden death .....

Injury

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. McKieffer Ewen MD M. D. or other

Address: 1010 Leadenhall Date signed 4-4-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00712

(954)

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs.

Hospital, institution, or street address where death occurred: Pleasant Hill Rd.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Owings Mill

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pleasant Hill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Henrietta Foel Easter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: James Miller Easter

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 9, 1860

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
86	8	17		

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: none

FATHER

12. Name: Gustave Foel

13. Birthplace: Germany

MOTHER

14. Maiden name: Elvine Van Lanten

15. Birthplace: Germany

16. Informant: Mrs. James W. Easter

Address: Pleasant Hill Rd Owings Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 28 1947 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md

18. Funeral director: Henry H. Jenkins Sons Co

Address: McCulloh & Orchard Sts.

19. 4-26-1947 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 April 1947, at 9 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1947 to Apr. 26 1947

and that I last saw her alive on 25 April 47 1947

Immediate cause of death	DURATION
Cardiorespiratory failure	8 hrs
Due to: Rheumatic Heart Disease	32 yrs.
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Paul H Royer M.D. M. D. or other

Address: 1225 Reisterstown Rd Pikesville 8, Md. Date signed: 2-6 Apr 47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


APR 29 1947

1046

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

CERTIFICATE OF DEATH

Reg. Dist. No. 00713

1. PLACE OF DEATH:
County: Baltimore
City or town: Nut. Washington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Timonium
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dawson Ave
(If rurol, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hannah J. Fendlay

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Harry E Fendlay
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Dec. 2 1878

8. AGE: Years	Months	Days	If less than one day
68	4	28	...hrs. ...min.

9. Birthplace: Maine (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Edward Powers
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Catherine Brown
MOTHER 15. Birthplace: Ireland
16. Informant: Harry E. Fendlay
Address: Timonium, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3 1947 (month) (day) (year)
Cemetery or crematory: St. Josephs
Location: Texas, Maryland
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.
19. May 2 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1947 at 11:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24 1947 to Apr. 30 1947 and that I last saw her alive on Apr. 29 1947

Immediate cause of death	DURATION
Cerebral Thrombosis 836	
c Left hemiplegia 836	
Due to: Aphonia & Aphagia	4 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: none
Date of op.:
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bennett A. Pleasants M. D. or other
Address: Cockeysville Date signed: 4/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

00714

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred: 433 Alabama Rd
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 433 Alabama Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elizabeth Jane Finn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 24, 1866

8. AGE: Years: 80 | Months: 7 | Days: 27 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Mt Washington - Balto Co.
(Town, county, and state)

10. Usual occupation: House wife Keeper

11. Industry or business:

FATHER
12. Name: James Finn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Sarah Jane Unknown
15. Birthplace: Ireland

16. Informant: Mrs Raymond Finn
Address: 433 Alabama Rd Towson

17. Burial (Burial, cremation, or removal, Which?) Date thereof: April 23-1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Towson, Maryland

18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road

19. April 22 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1947, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 19 46 to April 19 47
and that I last saw h.. alive on April 20 1947

	DURATION
Immediate cause of death: Heart Failure	1 Month
Due to: Hypertensive Cardio-Renal Vascular Disease	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

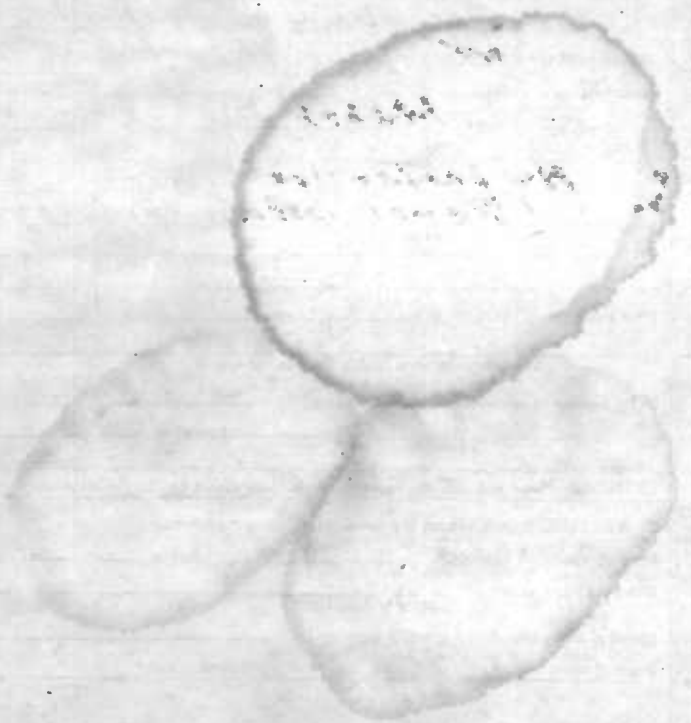
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

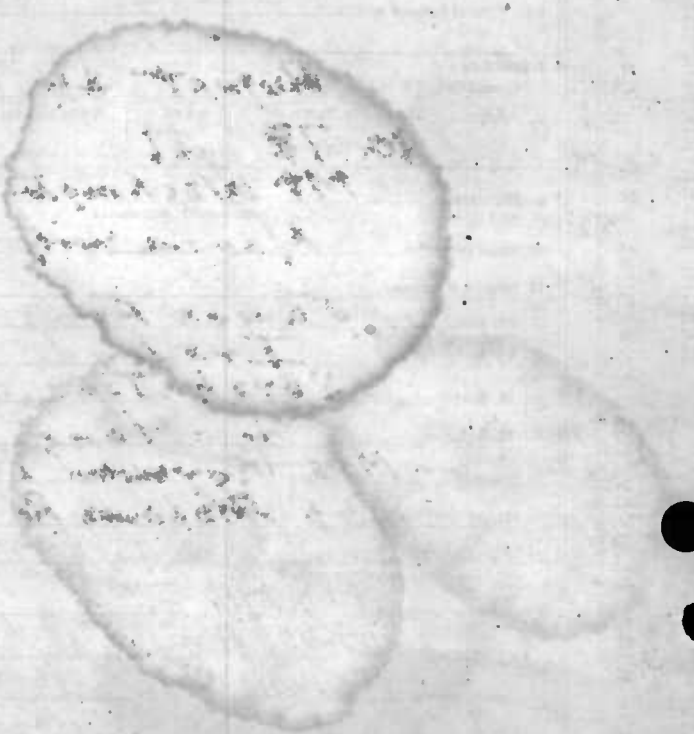
23. SIGNATURE: Charles F. Edmunds M.D.
M. D. or other
Address: 301 York Rd Date signed 4/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00715 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years, 5 months, 2 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 11years, 5 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1336 Fayette Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Fisher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 15, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	9	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Seaman

11. Industry or business: Sea

FATHER
12. Name: Joseph Steffy
13. Birthplace: ?

MOTHER
14. Maiden name: Florence Bond
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 5-7-47 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Md.

19. 5-7 1947 Harry Hulker Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1947 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22 1935 to April 24 1947 and that I last saw him alive on April 24 1947

	DURATION
Immediate cause of death: Acute heart failure	4 days
Due to: Chronic myocardial degeneration (fatty)	indefinite
Due to: Renal infarct	"
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other
Address: Catonsville-28, Maryland Date signed: 5-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(61)

00716

Reg. Dist. No. 3v

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County: Balto.
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos.
Hospital, Institution, or street address where death occurred:
4941 Cedar Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4941 Cedar Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MALVINA A. FLUTIE

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Abraham Flutie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 20, 1893

8. AGE: Years	Months	Days	If less than one day
53	8	26	..... hrs. ..... min.

9. Birthplace: Bierut, Syria
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: - Saba
13. Birthplace: Syria

MOTHER
14. Maiden name: --
15. Birthplace: Syria

16. Informant: Mr. Edward A. Flutie
Address: 4941 Cedar Ave., Relay

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4/17/47 (month) (day) (year)
Cemetery or crematory: Atlantic City, N. J.
Location

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 4-29-47 (Date rec'd by registrar) Henry L. Miller, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1947 at 7:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 March 1947 to 16 April 1947
and that I last saw h[illegible] alive on 16 April 1947

	DURATION
Immediate cause of death: Coronary occlusion	
Due to: Arteriosclerotic Heart Disease	4 yrs
Due to:	
Other conditions: Diabetes Mellitus	4 yrs
Hypertensive Cardiovascular Disease	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: (Bradley Daugherty) M.D. M. D. or other
Address: 1764 Francis Ave Halethorpe, Md. Date signed: 19 April 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 00717 / 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Balto

City or town: Bowleys Quarters

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Bowleys Quarters

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Andrew ~~Foehrkol~~ Foehrkolb,

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug - 19 - 1874

8. AGE:

Years	Months	Days	If less than one day
72	8	3	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Andrew Foehrkolb

13. Birthplace: Germany

MOTHER

14. Maiden name: Barbara Bretz

15. Birthplace: Germany

16. Informant: Joseph Foehrkolb

Address: 440 Eastern Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr - 24 - 47 (month) (day) (year)

Cemetery or crematory: Sacred Heart Cem

Location: O'Donnell St.

18. Funeral director: John F. Connelly

Address: 48 Eastern Ave

19. Apr 23 - 1947 (Date rec'd by registrar) John F. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-22-47 19..... at 10 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: AS-C-V-Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: M Bowers M.D. Dep. Med. Exam. - Balto. M.D. or other

Address: Dundalk Date signed 4-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462

D6718

Reg. Diat. No. 4[illegible]

1. PLACE OF DEATH:

County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred: 6419 Liberty Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6419 Liberty Road
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Anna Barbara Holtz

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William R. Holtz

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 14, 1859

8. AGE: Years	Months	Days	If less than one day
87	5	20	____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Christian Eisenhart
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Maryland

16. Informant: Mrs. Lawrence P. Molloy
Address: 6419 Liberty Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-7-47 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore, Md.

18. Funeral director: George L. Lahmeyer

Address: 2101 Frederick Ave.

19. April 3 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3, 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept — 1946 to April 1947 and that I last saw h[illegible] alive on April 2 — 1947

Immediate cause of death	DURATION
Carcinoma of bowel	
Due to: Chronic Myocarditis	
Due to: Chronic Nephritis	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Thos J Abbott M. D. or other

Address: 450 E Libert, Baltimore Date signed: 4-3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

06719

CERTIFICATE OF DEATH

Reg. Diat. No. ____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Buck's School house Rd.

Stay in hospital or inst. (yrs., or mos., or days): ____

Stay in this community (yrs., or mos., or days): ____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Md. Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Buck's School house Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME: Cora Furnkas

3. (b) Social Security Number: ____

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: John Furnkas

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 20, 1864

8. AGE:

Years	Months	Days	If less than one day
82	9	27	____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business: ____

FATHER
12. Name: John Baumiller
13. Birthplace: Germany

MOTHER
14. Maiden name: Cunigunda Gumpman
15. Birthplace: Germany

16. Informant: Mrs. Henry Comes (daughter)

Address: Buck's School house Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/19/47 (month) (day) (year)

Cemetery or crematory: St. Josephs

Location: Balto. Co. Md.

18. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Rd.

19. April 17 1947 (Date rec'd by registrar) Mrs. G. L. Reppman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16th 1947, at 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1947, to April 16th 1947, and that I last saw her alive on April 15th 1947.

Immediate cause of death	DURATION
Carcinoma of Stomach	2 yrs. (?)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ____

Of autopsy: ____

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: A. L. Wilkinson.
A. L. Wilkinson, M. D. M. D. or other

Address: 5713 Belair Rd. Date signed 4-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

0720 P

Reg. Diat. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2016 Summit Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clara R. Geipe

3. (b) Social Security Number:

4. Sex: F
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: A. Edgar Geipe
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): May 20th, 1888
8. AGE: Years: 59 Months: 11 Days: 4 If less than one day: hrs. min.
9. Birthplace: Baltimore. (Town, county, and state)
10. Usual occupation:
11. Industry or business: At House
FATHER 12. Name: Richard Ritter
13. Birthplace: Balto
MOTHER 14. Maiden name: Barbara Kellener
15. Birthplace: Balto
16. Informant: A. Edgar Geipe
Address: 2016 Summit Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 28-47 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem
Location: City
18. Funeral director: Merrick Funeral Home
Address: 2008 Orleans St
19. April 28 1947 (Date rec'd by registrar) A. W. Hedrick JS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1947 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to April 24 1947 and that I last saw her alive on April 23rd 1947

	DURATION
Immediate cause of death: Acute Cardiac dilatation	1 day
Due to: Myocardial Degeneration	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. V. Clift M.D. M. D. or other
Address: 5010 Greenleaf Road Date signed: 4-26-47

M

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

CERTIFICATE OF DEATH

00721

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Rosedale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs.

Hospital, institution, or street address where death occurred:

7843 Oakdale Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Rosedale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7843 Oakdale Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Gera Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Gera

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 22nd 1864

8. AGE: Years	Months	Days	If less than one day
82			..... hrs. ..... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual occupation Butcher

11. Industry or business Retired

FATHER 12. Name John Gera

13. Birthplace Hungary

MOTHER 14. Maiden name Esther —

15. Birthplace Hungary

16. Informant Mrs. John Gera Sr.

Address 7843 Oakdale Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 7 49 (month) (day) (year)

Cemetery or crematory Zion Luth. Cem.

Location Balto. Co. Md.

18. Funeral director Lansdale Funeral Home

Address 740 Belair Rd.

19. April 1947 John G. Connell Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1947 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan-10 1947 to April-4 1947

and that I last saw him alive on April-4 1947

Immediate cause of death	DURATION
Pneumonia Pleurisy and Stomach	2 yrs.
Due to Myocarditis Pulmonary Edema	3 D.
Due to Uremic Cystitis	
Other conditions Acute Manitus	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Wm. J. Geyer M.D. M. D. or other

Address 157 W. Mulberry Ave Date signed 4/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

60722

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 2M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 6 months, 13 days/years

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 8 years, 6 months, 13 days/years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 31 Carroll St.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Charles G. Gesner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Maude Stevens

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 4, 1889

8. AGE: Years	Months	Days	If less than one day
57	9	4	...hrs. ...min.

9. Birthplace: Annapolis, Maryland (Town, county, and state)

10. Usual occupation: barber

11. Industry or business: barber

FATHER — 12. Name: ?

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-11-47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: B. L. Hopkins & Son

Address: 170-172 W. St. Annapolis, Md.

19. 4-8-1947 (Date rec'd by registrar) Harry Hazelhurst Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 19 47 at 4 a. m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 26, 1938 19... to April 8 19 47 and that I last saw h... im... alive on April 8 19 47

Immediate cause of death	DURATION
Arteriosclerotic coronary disease	Indef.
Due to: Generalized arteriosclerosis	Indef.
Due to:	
Other conditions: Cochexia	4 months
Decubitus	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Isadore Tuerk M. D. or other

Address: Catonsville 28, Md. Date signed 4/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00724 8

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Ft. Pleasant
Stay in hospital or inst. (yrs., or mos., or days): 8 mos 12 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: (If outside city or town limits, write RURAL NEAR and give town) Ward No.
Street No.: 2104 Presbury St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Samuel Goldstein

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Bessie Goldstein
6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): ? ? 1876

8. AGE: Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: New York New York U.S.A. (Town, county, and state)

10. Usual occupation: Merchant.

11. Industry or business:

FATHER
12. Name: Aaron Goldstein
13. Birthplace: Poland

MOTHER
14. Maiden name: Hettie ?
15. Birthplace: Poland

16. Informant: Bessie Goldstein
Address: 2104 Presbury St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15, 1947 (month) (day) (year)
Cemetery or crematory: Hebrew Washington Rd Cemetery
Location: Washington Blvd

18. Funeral director: A.J. Iverson & Bros
Address: 1126 W. North Ave

19. April 12 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1947, at 3 30/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1946 to April 12, 1947, and that I last saw him alive on April 12, 1947

Immediate cause of death	DURATION
Myocardial failure.	
Due to Congestive Heart Failure	4 Years.
Due to Pulmonary Tuberculosis	1 Year.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert F. Shrier M.D
M. D. or other
Address: Pikesville, Md. Date signed: 4/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

06725 B

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Balto Co
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 6 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7008 Alden Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fannie K Garrell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife S Wilson Garrell
6.(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) Sept 6 th, 1870

8. AGE: Years	Months	Days	If less than one day
76	7	25	hrs. min.

9. Birthplace Va
(Town, county, and state)
10. Usual occupation
11. Industry or business At Home

FATHER
12. Name Augustus Applestall
13. Birthplace Germany

MOTHER
14. Maiden name Sophie Staubitz
15. Birthplace Balto

16. Informant S Wilson Garrell jr
Address 2906 Roslin Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 1947 (month) (day) (year)
Cemetery or crematory Loudon Park Cem
Location
18. Funeral director Ullrich Funeral Home
Address 2108 Allen St

19. 4/5 1947 (Date rec'd by registrar) C W Hedrich J.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947, at 1:30 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Nov. 25 1946, to April 2 1947
and that I last saw h.er alive on April 1 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to Debility	
Due to Hypertension	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE N L Grantham M. D. or other
Address Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00726

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years, 8 months, 18 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 14 years, 8 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1026 Brentwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine Gover

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife: Charles Gover

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1857?

8. AGE:

Years	Months	Days	If less than one day
90?	?	?	hrs. min.

8. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: Nicholas Hilt

13. Birthplace: ?

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-7-47 (month) (day) (year)

Cemetery or crematory: Spring GroveState Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 5-7- 1947 (Date rec'd by registrar) Harry L Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1947 at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6- 1932 to April 24 1947 and that I last saw her alive on April 24 1947

	DURATION
Immediate cause of death: Aortic stenosis - arteriosclerotic	indefinite
Due to: Arteriosclerotic cardio-renal disease;	indefinite
Due to: Chronic interstitial nephritis	"
Senility	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5-5-47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-5M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

8

06727

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Several years.
Hospital, Institution, or street address where death occurred: at Home
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 602 W Allegheny Av
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME Ada Virginia Graw

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles T Graw
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) About May 17 1872

8. AGE: Years	Months	Days	If less than one day
Abt 74	10	18	____ hrs. ____ min.

9. Birthplace Philadelphia Pa
(Town, county, and state)
10. Usual occupation none
11. Industry or business none

FATHER
12. Name Marvin C. Garrett
13. Birthplace probably Penna.

MOTHER
14. Maiden name Virginia Young
15. Birthplace probably Penna.

16. Informant Mr Gilbert Hudson (Son)
Address Towson Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 7 47 (month) (day) (year)
Cemetery or crematory Harleigh
Location Camden N J

18. Funeral director Stewart Mortuary Company
Address 108 W North Av Balto.

19. 4/5 (Date rec'd by registrar) 1947 A W Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1947, to April 4 1947
and that I last saw h. alive on April 4th 1947

Immediate cause of death	DURATION
Acute Cardiac Collapse	1 day
Due to Arteriosclerosis	
Myocardial Insufficiency	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause tu which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel J & Thos. Jenifer M. D. or other
Address Towson 4 Md Date signed April 5 1947

J.C.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00728

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nettie Henrietta Graybill

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jerome Victor Graybill deceased
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept, 15, 1868

8. AGE: Years	Months	Days	If less than one day
78	6	27	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Henry Crane
13. Birthplace: New York N.Y.

MOTHER
14. Maiden name: Rhoda Ann Spellman
15. Birthplace: New York

16. Informant: Louis Maurice Graybill
Address: Owings Mills, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 15, 1947 (month) (day) (year)
Cemetery or crematory: Woodland
Location: Philadelphia, Pa
18. Funeral director: Frank H. Newell Inc.
Address: Pikesville, Maryland

19. 4-14-1947 (Date rec'd by registrar) Dr. E. E. Nichols MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1947, at 6.15 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11- 1946, to April 11- 1947 and that I last saw her alive on April 11- 1947

Immediate cause of death: Carcinoma of uterus & general debilitated metastasis — DURATION: 2 yrs?
Due to:
Due to:
Other conditions: Hernia Diaphragmatic & senility
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols, MD
M. D. or other
Address: Pikesville 8. Md. Date signed: 4-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06729 P

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
27 Somerset Rd.
How long in hospital or Institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 27 Somerset Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EVALINE ISABELLA HALL

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1864

8. AGE: Years	Months	Days	If less than one day
82	6	12	..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: George W. Hall
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Jane Elliott
15. Birthplace: Md.

16. Informant: Mr. Roland Mcoubbin
Address: 27 Somerset Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/2/47 (month) (day) (year)
Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 5-1 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 April 1947, to 30 April 1947
and that I last saw h.e.r alive on 29 April 1947

Immediate cause of death	DURATION
Cerebro-vascular accident (Cerebral hemorrhage)	1 week
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Douglas Lockard, M. D. or other
Address 28 E. Cathedral St. Date signed May, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-A)

CERTIFICATE OF DEATH

06730

Reg. Dist. No. .....

1. PLACE OF DEATH

County ..... Baltimore

City or town ..... Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... Register Ave.

Hospital, institution, or street address where death occurred:

Armacost Nursing Home

How long in hospital or institution? ..... 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME MIRIAM EARLE HANNA

3.(b) Social Security Number **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife ..... John Leland Hanna

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ..... Dec. 20, 1859

8. AGE: Years	Months	Days	If less than one day
87	4	4	..... hrs. ..... min.

9. Birthplace ..... Greenville, S. C.
(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER 12. Name ..... Henry M. Earle

13. Birthplace ..... S. C.

MOTHER 14. Maiden name ..... Sophie F. Roland

15. Birthplace ..... S. C.

16. Informant ..... Mrs. Paul A. Fleury

Address ..... 2830 N. Calvert St.

17. ..... Burial ..... Date thereof 4/26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Sherwood Episcopal

Location ..... Cockeysville, Md.

18. Funeral director ..... WM. J. TICKNER & SONS

Address ..... Balto., Md.

19. ..... 4/25 ..... 19 47 ..... H. W. Hedrick ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... April 24, ... 19 47 ..... at 9:15am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 19 47, to April 23, 19 47 and that I last saw her alive on April 23, 19 47

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to Arteria-Sclerosis & Hypertension	Unk.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hunt Kellam M.D.

Address Towson - Md. M. D. or other

Date signed 4/25/47.

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00731

Reg. Diat. No.

1. PLACE OF DEATH:

County: Balto.

City or town: Villa Nova
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Robb Nursing Home, Essex Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1324 Eutaw Place
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HILDEGARDE HARRINGTON

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Elisha Harrington
13. Birthplace: Balto., Md.

MOTHER
14. Maiden name: Aarah G. Hagany
15. Birthplace: Wilmington, Del.

16. Informant: Mrs. Florence M. Altemus
Address: 3232 Ellicott St., N. W., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/12/47 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 4-11 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 19 47 at 9:15 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 40 to April 10 19 47 and that I last saw h[illegible] alive on April 9 47 19

Immediate cause of death	DURATION
My dear doctor:	Gradual ✓
Hyperpyrexia ✓	
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Healy M. D. or other

Address: 1403 Park Ave. Date signed: 4/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1220)

CERTIFICATE OF DEATH

00732

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Belair Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Belair Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Isabelle Heaps

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Benjamin Heaps
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 8 1858

8. AGE: Years	Months	Days	If less than one day
89	3	7	..... hrs. ..... min.

9. Birthplace Baltimore City Md
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name --- Lucas
13. Birthplace -

MOTHER
14. Maiden name -
15. Birthplace -

16. Informant Mrs Albert Holthaus
Address Belair Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/17/47 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Baltimore
18. Funeral director Lassahn Funeral Home
Address 7401 Belair Rd. Balto 6 Md
19. April 16 19 47 (Date rec'd by registrar) Mrs A. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 1:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 40 to April 15 19 47 and that I last saw h[illegible] alive on 4-15 19 47

Immediate cause of death	DURATION
Cancer of Colon	
Due to Obstruction & Hyperplasia	
Due to	
Other conditions Ventral Hernia	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Michael Jansfield MD M. D. or other
Address 7401 Belair Rd Date signed 4-15-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

Lt. Grossfeld
5402 Belair Rd
6-8 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

pc U0733 32

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 2 mos., 1 day

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1701 Crystal Ave., Baltimore, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Mrs. Mildred Louise Henderson

3.(b) Social Security Number 216-05-1631

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Milton Henderson

6.(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) May 7, 1909

8. AGE: Years 37 | Months 10 | Days 28 | If less than one day .....hrs. .....min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business .....

FATHER 12. Name William F. Sullivan

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Jennie Jenkins

15. Birthplace Baltimore, Maryland

16. Informant Mildred Henderson

Address 1701 Crystal Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 7, 1947 (month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Washington, D. C.

18. Funeral director John C. Miller, Inc.

Address 2435 E. Oliver St., Balto., Md.

19. April 4 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3, 1947, to April 4 1947 and that I last saw her alive on April 4, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 yrs.
Due to Tubercle Bacilli	
Due to	
Other conditions Lipoid Nephrosis	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operation No operation

Date of op. .....

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. I. Siegel M.D. M. D. or other

Address Mount Wilson, Md. Date signed 4/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45


APR 8
BUREA

06734 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 30

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 4 months 5 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 5 years, 4 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1012 Patapsco St.
(If rural, give LOCATION)
2.(a) If veteran, name war -

3.(a) FULL NAME
HENRY HENKLE

3.(b) Social Security Number
-

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife -
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 14, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	1	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business own business

FATHER
12. Name Hospital Records
13. Birthplace Catonsville 28, Md.

MOTHER
14. Maiden name Mary Hinkel
15. Birthplace Balto. Md.;

16. Informant Mrs. George Rehling
Address 1723 E. 29th St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18 47 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Ritchie Highway

18. Funeral director Krause Funeral Home
Address 1216 E. Chase St.

19. April 17 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 at 7 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1941 to April 15 1947 and that I last saw him alive on April 15 1947

Immediate cause of death	DURATION
Arteriosclerosis	Indef.
Due to cardiac failure	Indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results no.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Isadore Tuerk
Address Catonsville 28, Md. M. D. or other
Date signed 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0735

Reg. Diat. No. 39

1. PLACE OF DEATH.
County Baltimore
City or town Monkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Monkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clara Bell Hild

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Charles W. Hild
6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1864

8. AGE:

Years	Months	Days	If less than one day
82	5	22	hrs. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name David A. Sutton
13. Birthplace unknown
MOTHER 14. Maiden name Ellen Carlin
15. Birthplace unknown
16. Informant Mrs. J. M. Hartman
Address Monkton, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof 4-19-47 (month) (day) (year)
Cemetery or crematory Wesley Chapel Methodist
Location Sandon Rd. Brooklandville Md
18. Funeral director Sandon M. Brooks
Address Parkton
19. 4/18/1947 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947 at 5:6 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 6 1947 to April 16 1947 and that I last saw h...es... alive on April 12 1947

Immediate cause of death	DURATION
Uremia	
Due to Chronic nephritis	
Due to	
Other conditions Chronic hypocardia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. M. Frames M. D. or other
Address Parkton, Md. Date signed 4/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

06736

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1828 McHenry Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Katie Holland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Holland

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): 1886? December 30,

8. AGE: Years: 60? Months: 3 Days: 20 If less than one day: hrs. min.

9. Birthplace: Cairo, Georgia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Frank Richter

FATHER — 13. Birthplace: Georgia.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Georgia.

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-23-47 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore

18. Funeral director: Frederick A. Cole

Address: 1700 W. Lombard St

19. April 22 19 47 (Date rec'd by registrar) A. W. Bedsuch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 19 47 at 4:15 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 47 to April 20 19 47 and that I last saw her alive on April 20 19 47

Immediate cause of death	DURATION
Acute exacerbation of myocardial insufficiency	11 days
Due to: Auricular fibrillation	indefinite
Left hemiplegia	indefinite
Due to: Pseudobulbar paralysis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 4-21-47

M

I

VS A15 9-45 5M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of "usual residence of deceased" shown on

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

940a

Reg. Dist. No. 44

JUN 13 1947 FILM No. G 110 JUN 13 1947

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Balto.

(b) City or town Rosedale
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Chesapeake Brick Co Yard Philpot St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Rosedale
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Lawrence Holt

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. **AGE:** Years About 60. | Months | Days | If less than one day ____hr. ____min.

9. Birthplace
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 2 47 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Texas Md

18 (a) Funeral director H. Brey Kunkel

(b) Address 1407 E. Baltimore St

19 (a) 6-2-47 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. **Date of death** 4/1/47, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19____, to 19____, and that I last saw him alive on 19____.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** W M Barnum M.D.
M. D. or other

Address Deputy Medical Examiner Dundalk Md Date signed 4/11/47

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

00737 P

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Baltimore
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 Avon Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice E. Humphrey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William H. Humphrey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1881

8. AGE: Years	Months	Days	If less than one day
66	0	26	hrs. min.

8. Birthplace: Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —
FATHER 12. Name: Mitchell
13. Birthplace: —
MOTHER 14. Maiden name: —
15. Birthplace: —
16. Informant: Wm. H. Humphrey
Address: 16 Avon Ave., Turners Station
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23, 1947 (month) (day) (year)
Cemetery or crematory: Oaklawn
Location: Eastern Ave.
18. Funeral director: Roland L. Fisher
Address: 2112 Dundalk Ave.
19. 4/22 1947 Alice Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1947, at 3.25 P. M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from Feb. 7 1947 to Apr. 20 1947 and that I last saw h alive on April 17th 1947

Immediate cause of death	DURATION
(a) C-V Renal Disease	15 yrs.
Due to (b) Diabetes Mellitus	10 yrs.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. W. Davis M.D.
M. D. or other
Address: Dundalk
Date signed: 4/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

60738

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore Co.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Edgewood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore Co.

City or town: Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edgewood Road

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: John T. Humphreys

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Carrie C. Humphreys

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 1, 1864

8. AGE: Years: 82 Months: 8 Days: 12 If less than one day: ..... hrs. ..... min.

9. Birthplace: Catonsville Balto. Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer retired

11. Industry or business:

FATHER 12. Name: John T. Humphreys

13. Birthplace: Baltimore Co. Md.

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: William E. Humphreys

Address: Edgewood Rd. Woodlawn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Baltimore, Md.

18. Funeral director: Easton Sons

Address: Edmondson City, Md.

19. 4/13/47 (Date rec'd by registrar) Thos. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 13 1947 at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1947, to Apr. 13, 1947

and that I last saw him alive on Jan. 13 1947

Immediate cause of death	DURATION
Gangrene of foot	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. E. Martin M. D. or other

Address: Randallstown Date signed 4/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00739

Reg. Diat. No. 4X

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 36 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Mosher Street (If rural, give LOCATION)

2.(a) If veteran, name war: W"-2

3.(a) FULL NAME: CHARLES HUNTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Virginia

6.(c) If alive, give age: 18 years

7. Birth date of deceased (mo., day, yr.): 7-23-1923

8. AGE: Years	Months	Days	If less than one day
23	8	14	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: Sadie Lewis

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-10-47 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Maryland

18. Funeral director: Charles L. Law

Address: 802 Madison Avenue

19. 4/8 47 (Date rec'd by registrar) A W Hadrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1947, at 6:15 a M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Jannary 30, 1947, to April 7, 1947 and that I last saw h. im alive on April 7, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

R.M. CULLISON, M.D. CLIN. DIR. M. D. or other

Address: V.A.H. FT. HOWARD, MD. Date signed: 4-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (938)

CERTIFICATE OF DEATH

06740

Reg. Dist. No. 34

1. PLACE OF DEATH:
County Baltimore
City or town Trenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto
City or town Trenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish-American War

3. (a) FULL NAME Joseph J Jessa

3. (b) Social Security Number 705-05-6193

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	divorced

6.(b) Name of husband or wife unknown
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 - 1872

8. AGE: Years 74 | Months 9 | Days 28 | If less than one day hrs. min.

9. Birthplace Brian, Ohio
(Town, county, and state)

10. Usual occupation Retired Engineer

11. Industry or business Railroad.

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mrs Anna Trampleton
Address 1618 Webster St - Balto Md

17. Burial Date thereof April 4/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Bartholomews
Location Manchester - Md

18. Funeral director Edw C Tipton
Address Hampstead, Md

19. April 3 1947 April 3 1947 Fred [illegible]
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1947, to Mr 1947
and that I last saw him alive on March 30 1947

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to Generalized Arthritis-Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph E Bell M.D. M. D. or other
Address Hampstead Md Date signed 4-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

00741

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk - Rr Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
1758 Brookview Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1758 Brookview Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eliza Ellen Jessee.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Widowed.

6.(b) Name of husband or wife Joseph L. Jessee
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1866.

8. AGE: Years	Months	Days	If less than one day
80	11	12	hrs. min.

9. Birthplace Va
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Jno Jessee
13. Birthplace Va

MOTHER
14. Maiden name Ellen Browning
15. Birthplace Va

16. Informant Mrs. Cora Tommeny
Address 1715 Brookview Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17th (month) (day) (year)
Cemetery or crematory Darlington Cem
Location Darlington Md
18. Funeral director Ulrich Funeral Home
Address 2008 Orleans St

19. April 16 1947 (Date rec'd by registrar) Mabel R. Smelser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946, to April 1947, and that I last saw h alive on April 15 1947

Immediate cause of death	DURATION
Cerebral Accident	3 days
Due to Arterio-Sclerotic C-V Disease	5 yrs
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M Davis M.D. M. D. or other
Address Dundalk-Rr Date signed 4/16/47

Form 10 Revised

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 9-45 5M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

00742

Reg. Diat. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 557 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Leonard Augustus Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Evelyn P. Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 6, 1900

8. AGE: Years	Months	Days	If less than one day
46	8	17	hrs. min.

9. Birthplace: Balto. Co.
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: " "

MOTHER
14. Maiden name: Eliza Madden
15. Birthplace: Balto. Co.

16. Informant: Eva Madden
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25, 1947 (month) (day) (year)
Cemetery or crematory: St. Lukes
Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. 4-25-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-23-47 19 at 19 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
and that I last saw him alive on 4-22-47 19

Immediate cause of death	DURATION
Cerebral hemorrhage	1 week
Arteriosclerosis	
Due to: Hypertension &	
Due to: Poor heart	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Daffel M. D. or other
Address: Reisterstown Md. Date signed: 4/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(83a)

Reg. Dist. No. 007433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Railroad Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lewis Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57				

9. Birthplace: GreenSpring Valley Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James Johnson
13. Birthplace: Md.

MOTHER
14. Maiden name: Fannie Harlem
15. Birthplace: Md.

16. Informant: M's Josephine Johnson
Address: Railroad Av. Greenspring Valley

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 4-17-47
(month) (day) (year)
Cemetery or crematory: St. Luke's Cem
Location: Reisterstown, Md.

18. Funeral director: Mrs. Frances A. Kemsley
Address: 578 W. Biddle St.

19. April 16 1947 A. W. Pearce
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1947, at 2:30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-14-'47 1947 to 4-14-'47 1947 and that I last saw him alive on not seen alive 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	15 min.
Due to Epilepsy	5 yrs.?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? NONE
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. D. Caples M. D. Med. Examiner
M. D. or other
Address: Reisterstown, Md. Date signed: 4-14-'47

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

00744

FILM No. G 11 MAY 7 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Balto.
City or town Longueau Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Longueau Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lenore P. Kane

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 2 - 1860

8. AGE:

Years	Months	Days	If less than one day
96 ~~85~~	7	22	..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Lorenzo Patterson
13. Birthplace Md.

MOTHER
14. Maiden name Mary Caldwell
15. Birthplace Md.

16. Informant Marjorie P. Kane
Address Longueau, Md.

17. Burial Date thereof April 26-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Chestnut Grove
Location Sweet Air Md.

18. Funeral director Clarence E. Arthur
Address Fork Md.

19. April 25 1947 C. E. Arthur
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1947, to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	5 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.
M. D. or Other
Address Md. Date signed 4/25/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00745

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Owings Mills Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs 5 mos
Hospital, Institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 36 yrs 5 mos (retired Employee)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rosewood State Training School
(If outside city or town limits, write RURAL and give nearest town)
Street No. Owings Mills
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eliza Goldsborough Kerr

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26, 1866

8. AGE: Years 81 | Months 0 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Retired Employee of Rosewood

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Institutional Records: Rosewood
Address State Training School: Owings Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20-47 (month) (day) (year)
Cemetery or crematory St Thomas
Location Balto Co.

18. Funeral director J. F. Eleni. Sons
Address Reisterstown Md.

19. APR 1 19 19 47 (Date rec'd by registrar) Mary B. E Line. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 47 at 2:04 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 43 to April 18 19 47
and that I last saw her alive on April 18 19 47

	DURATION
Immediate cause of death: Coronary Occlusion	2 days
Due to: Generalized Arteriosclerosis with Senility	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op. none
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C. Medairy M. D. M.D. or other
Address Owings Mills, Md Date signed 4/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M


APR 22 '94
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a)

00746

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore.
City or town Owings Mills.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore.
City or town Owings Mills.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Caves Road near Park Heights.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Keys.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White.	Widowed.

6.(b) Name of husband or wife Edward F. Keys.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) August 3, 1862

8. AGE: Years	Months	Days	If less than one day
84	8	3	....hrs. ....min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation None.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Charles R. Keys.
Address Charles Road, North Linthicum.

17. Burial. Date thereof April 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Woodlawn.
Location

18. Funeral director Chenoweth & Donovan.
Address 3615-17 Chestnut Ave.

19. 4-8-1947 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 1230 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1947, to April 7 1947
and that I last saw her alive on April 7-47 1947

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to Coronary Artery Disease	
Due to Arterio Sclerosis	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E E Nichols MD
M. D. or other
Address Pikesville Md Date signed 4-8-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-A)

00747 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 603 Edgevale Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Koerner

3.(b) Social Security Number:

4. Sex: female.
5. Color or race: white.
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife:
6.(c) If alive, give age: 4 years
7. Birth date of deceased (mo., day, yr.): Nov 17 - 1862.
8. AGE: Years: 84. Months: 5. Days: 0. If less than one day: hrs. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: house work
11. Industry or business: at home
FATHER 12. Name: Thomas Koerner
13. Birthplace: Germany.
MOTHER 14. Maiden name: Mary Hesing.
15. Birthplace: Germany.
16. Informant: Mr Edward Koerner
Address: 603 Edgevale Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/21/47 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem
Location: 4300 Old Frederick Road
18. Funeral director: John E Gowan & Son
Address: 901-2 Collins St.
19. April 18 1947 (Date rec'd by registrar) a. w. Harris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17th 1947, at 5 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 - 1947 to April 17 1947 and that I last saw h[illegible] alive on April 17 1947.

	DURATION
Immediate cause of death: Pulmonary Oedema	
Due to: Arteriosclerosis	
Due to: Myocarditis	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Norton C Nitsch M. D. or other
Address: 2151 W Lanvale Av Date signed 4/18/47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00748 P

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows Point (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For new-born infants give residence of mother)
State Md. County Baltimore
City or town Sparrows Point (If outside city or town limits, write RURAL and give nearest town)
Street No. 2946 Sollers Point Road. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ROBERT LANDON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Kate Keane
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Nov 29th 1880.

8. AGE: Years	Months	Days	If less than one day
66.	4	22	..... hrs. ..... min.

9. Birthplace Laurel, Md. (Town, county, and state)
10. Usual occupation
11. Industry or business Retired
FATHER 12. Name James Landon
13. Birthplace Md.
MOTHER 14. Maiden name Sarah E. Delaney
15. Birthplace Md.
16. Informant Mrs Bertha Hecker
Address 2946 Sollers Point Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/23/47 (month) (day) (year)
Cemetery or crematory Mt Olivet Cem
Location 2330 Federick Ave
18. Funeral director John J Cowan & Son
Address 901-03 Hollins St
19. 4/21 1947 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 20 1947 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPTEMBER 1946 to APR. 1947
and that I last saw him alive on APRIL 20 1947
Immediate cause of death RESPIRATORY FAILURE — DURATION 1 DAY
Due to ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations NONE Date of op.
Autopsy results NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Stephen C. Mackoviak M.D. (M. D. or other)
Address 6714 Holabird Ave Date signed April 20 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

53

00749

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1039 Beechfield Ave.
How long in hospital or institution? 65 yrs. In State

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1039 Beechfield Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Lawson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: late Mary Louise Lawson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 12, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80	10	29		

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER — 12. Name: Joseph Lawson
13. Birthplace: Ireland
MOTHER — 14. Maiden name: Anna —
15. Birthplace: Ireland
16. Informant: Leila Henke
Address: 1039 Beechfield Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 | 14 | 47 (month) (day) (year)
Cemetery or crematory: London Pk
Location: 3801 Frederick Rd
18. Funeral director: Harry H. Nitzke
Address: 4101 Edmondson Ave
19. April 15, 1947 (Date rec'd by registrar) A. W. Yodsuch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1947, at 3:55 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February, 1946, to April 11, 1947, and that I last saw him alive on March 14, 1947.

Immediate cause of death: Arteriosclerotic Cardio Vascular Clio — DURATION: 3 yrs
Basal cell carcinoma Skin-Face — 4 yrs
Due to:
Due to:
Other conditions: Paralysis Ag. Face — 10 yrs
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl Pass, M.D.
M. D. or other
Address: 4001 Arbutus Ave
Date signed: 4-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

00750

P

CERTIFICATE OF DEATH

Reg. Dist. No. 42

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45

1. PLACE OF DEATH:

County: Balto

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3115 Hilltop Ave

(If rural give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Elizabeth Funk.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 25 1865

8. AGE: Years: 81 Months: 11 Days: 10 If less than one day: ..... hrs. ..... min.

9. Birthplace: ~~Hanover~~ Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Henry Oelring

13. Birthplace: Germany

MOTHER 14. Maiden name: Julia Kerr

15. Birthplace: Germany

16. Informant: John Funk

Address 3115 Hilltop Ave Balto Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/8/47 (month) (day) (year)

Cemetery or crematory: Forest Lawn Park Cem

Location: Frederick Rd.

18. Funeral director: Edward Faulkner

Address 2307 Gwynn Blvd Balto 30 Md

19. 4-7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1947, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17 1939, to April 5 1947

and that I last saw h.er alive on April 5 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Vascular Disease	?
Due to	
Due to	
Other conditions: Hypertension	?
Cerebral Hemorrhage	1941

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Carl P Rosting M. D. or other

Address 1326 W Lombard St Date signed 4/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

00751

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 601 Allegheny Avenue
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 601 Allegheny Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ////////

3. (a) FULL NAME: LYDIA ANN LINS

3. (b) Social Security Number: ////////

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Henry Jacob Lins
6(c) If alive, give age: ///// years

7. Birth date of deceased (mo., day, yr.): February 5, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	21	hrs. min.

9. Birthplace: Sweet Air, Balto. Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Daniel Gilbert
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Anna Marie Burk
15. Birthplace: Penna.

16. Informant: Miss Helen J. Lins
Address: 601 Allegheny Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1947 (month) (day) (year)
Cemetery or crematory: St. John's Luthern Cemetery
Location: Blenheim, Balto. Co., Md.

18. Funeral director: John Burns Sons
Address: Towson, Maryland

19. Apr. 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1947, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1947 to April 25 1947, and that I last saw her alive on April 25, 1947

Immediate cause of death	DURATION
Carcinoma (Cecum)	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hurt Green M.D. M. D. or other
Address: Towson-4-Md. Date signed 4/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00752 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

Reg. Dist. No. 30

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 11 months, 3 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 3 years, 11 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2912 Evergreen Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: HELEN W. LOTZ
3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	divorced

6.(b) Name of husband or wife: Edward Lotz
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 13, 1872

8. AGE: Years	Months	Days	If less than one day
74	9	2	... hrs. ... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: storekeeper
11. Industry or business: storekeeping

FATHER
12. Name: ? Windburg
13. Birthplace: germany

MOTHER
14. Maiden name: ?
15. Birthplace: Germany

16. Informant: Hospital Records
Address: Baltimore 28, Catonsville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 4-18-47 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location: Baltimore Md.

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Rd.

19. 4-18 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1947, at ~~4:05~~ 7:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Broncho Pneumonia
Due to: Cardio vascular disease + renal
Due to: Sub dural hemorrhage due to a fall on stairway
Other conditions: falling on face + fore head Accident
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: as above
Date of op.
Autopsy results: Yes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 3-29-47
Where did injury occur? Catonsville Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Hospital
Means of injury: fell on fore head
Injured at work: no

23. SIGNATURE: Geo. M. Kieffer Dep Med Exam. Balto Co. M.D. or other
Address: 1010 Leeds ave Date signed: 4-17-47

Dr. Harbold.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00753 P

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
17 Longanore Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Parkville
City or town Baltimore 16
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2604 Hindsor Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William O. Louis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Rita K. Louis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20-1903

8. AGE: Years 44 | Months — | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Foreman Sheet Metal
11. Industry or business
FATHER 12. Name John J. Louis
13. Birthplace Md.
MOTHER 14. Maiden name Katherine Reinhardt
15. Birthplace Md.
16. Informant Mrs. Rita K. Louis
Address 2604 Hindsor Ave.
17. Burial Date thereof 4-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parkwood
Location Baltimore
18. Funeral director Leonard J. Keck
Address 5305 Harford Road.
19. 4/25 1947 A. W. Hedrick DM
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1947, at 8:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 1944, to April 22 1947
and that I last saw him alive on April 22 1947

	DURATION
Immediate cause of death Cerebral Thrombosis (left) (Recurrent thrombi)	14 Months
Due to Mesenteric thrombosis	
Due to Auricular Fibrillation	
Due to Chronic myocarditis	
Other conditions Aphasia	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. V. Harbold M.D.
M.D. or other
Address Baltimore, Md. Date signed 4/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

00754 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51C

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto Co.
City or town Baltimore (20) (If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Taxiway (If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3.(a) FULL NAME CALVIN A LOWREY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Fredericka Lowery 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-23-18

8. AGE: Years	Months	Days	If less than one day
28	9	8	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Walter Lowrey
13. Birthplace Maryland

MOTHER
14. Maiden name Lillian Schaeffer
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1947 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Frederick Road.
18. Funeral director Roland L. Frahm
Address 7112 Dundalk ave.
19. 4-2 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947, at 3:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1947 to April 1, 1947 and that I last saw him alive on April 1, 1947

Immediate cause of death	DURATION
Progressive hemorrhage from gastro-intestinal tract	1 week
Due to: Teratoma of right testicle with generalized metastasis and xxx carcinomatosis	7-9 months
Other conditions Absence of rt. testicle acquired,	7 Months

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M.D. or other
R.M. CULLISON, M.D. CLIN. DIR.
Address V.A.H. FORT HOWARD, M.D Date signed 4-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06755

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 7 months, 7 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 7 years, 7 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 858 Fayette Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James W. Lowry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 21, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	2	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business: None

FATHER
12. Name: John B. Lowry
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary MacMarkin
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-7-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 5-7 (Date rec'd by registrar) 19 47 Harold L. Mullen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 47 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 16 19 39 to April 23 19 47 and that I last saw him alive on April 23 19 47

Immediate cause of death	DURATION
Adhesive pericarditis	indefinite
Due to: Urinary tract infection (left renal abscess)	3 months
Due to: Broncho pneumonia, right lower lobe	24 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Baltimore-28, Maryland Date signed: 5-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 12M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-a)

CERTIFICATE OF DEATH

00756 P

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 701 Symington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Nora G. Lynch

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: late Robert E.
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug 14th 1888

8. AGE: Years	Months	Days	If less than one day
58	8	12	____ hrs. ____ min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: house work
11. Industry or business: at home
FATHER 12. Name: John Gaskill
13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Sellah Slabe
15. Birthplace: Baltimore, Md.
16. Informant: Mrs Mildred Behling
Address: 701 Symington Ave Catonsville Md
17. Burial (Burial, cremation, or removal. Which?): Burial Date thereof: 4/29/47 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: 5501 Frederick Ave
18. Funeral director: John J. Bowman & Son
Address: 00-03 Collins Ave
19. April 28 1947 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26th 1947, at 3.53 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1946 to Apr. 26 1947 and that I last saw h...er alive on Apr. 24 1947

Immediate cause of death	DURATION
Coronary Embolism	1 hr.
Due to: Cerebro-Vascular Renal Disease	2 yrs
Due to: Hypertension	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Roger E. Moran M. D. or other
Address: Catonsville 28 Md. Date signed: 4-26-47

U6757 C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 138

CERTIFICATE OF DEATH

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 166

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md

How long in hospital or institution? 166

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County ~~Baltimore~~

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 715 Dennison Street
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME HUDY MACKEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Lena Mackey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-20-95

8. AGE: Years	Months	Days	If less than one day
51	5	6	..... hrs. ..... min.

9. Birthplace Macedona, Ill
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

FATHER 12. Name Miller Mackey

13. Birthplace Illinois

MOTHER 14. Maiden name Agnes Gibbs

15. Birthplace Illinois

16. Informant Clinical Records, Vets Adm Hosp
Address Fort Howard, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1947 (month) (day) (year)

Cemetery or crematory Balto Natl Cemetery

Location Baltimore, Md

18. Funeral director Harry H. Witzke

Address 4101 Edmundson, Avenue

19. April 28 1947 (Date rec'd by registrar) P. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 3:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11 1946 to April 26 1947 and that I last saw h im alive on April 26 1947

Immediate cause of death	DURATION
Tbc; chr. pul. far advanced	166 da. plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Robert M. Cullison

23. SIGNATURE R.M. CULLISON, M.D. CLIN. DIR. M. D. or other

Address V.A.H. FO RT HOWARD, MD Date signed 4-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48

CERTIFICATE OF DEATH

00758

Reg. Dist. No. 37

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Quaker Bottom Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sparks
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Quaker Bottom Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cora Belle Madden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Frank Edward Madden
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): March 15, 1902

8. AGE: Years	Months	Days	If less than one day
45	1	14	..... hrs. ..... min.

9. Birthplace: Chincoteague, Virginia (Town, County, and State)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: John Hussey
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lucy Davage
15. Birthplace: Chincoteague, Virginia

16. Informant: Frank Edward Madden
Address: Quaker Bottom Rd. Sparks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1947 (month) (day) (year)
Cemetery or crematory: Stephenson Chapel
Location: Sparks, Md.
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. 4-29 (Date rec'd by registrar) 19 47 Wilmer C. Emgor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 April 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 March 1947, to 26 April 1947
and that I last saw her alive on 26 April 1947

	DURATION
Immediate cause of death: Cancer of Uterus	15 mons.
Due to:	
Due to:	
Other conditions: Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kuss M.D. M. D. or other
Address: Cockeysville Md Date signed: 4-29-47

Evidence for change of birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE NO. G 110 JUN 3 1947 **CERTIFICATE OF DEATH**

00754 8

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Baltimore

City or town Towson 4, Maryland (If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? Since June 12, 1946

Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since June 12, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore 21st D (If outside city or town limits, write RURAL and give nearest town)

Street No. 7613 Cypress Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Mahaley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Charles W. Mahaley

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) January 30, ~~1937~~ 1909

8. AGE: Years	Months	Days	If less than one day
38			hrs. min.

9. Birthplace Mt. Kusheet Pa (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

FATHER 12. Name Michael Gotkavich

13. Birthplace Yugoslavia

MOTHER 14. Maiden name Dorothy Kusich

15. Birthplace Yugoslavia

16. Informant Personal History-Hospital Records

Address Eudowood Sanatorium, Towson 4, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof April 9 1947 (month) (day) (year)

Cemetery or crematory Mt. Koesper Pa

Location same

18. Funeral director Welsh Funeral Home

Address 2008 Orleans St

19. 4-8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 12 1946 to April 7 1947

and that I last saw h.. alive on April 7 1947

	DURATION
Immediate cause of death	
Pulmonary Tuberculosis	Since December 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Bridges M. D. or other

Address Towson 4, Maryland Date signed 4-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

P 00760

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Spring Grove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Kate Augusta Martin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 1857

8. AGE: Years 89 | Months 4 | Days | If less than one day hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Charles J. Martin
13. Birthplace New Orleans, La.

MOTHER 14. Maiden name Harriet
15. Birthplace Middletown, Conn.

16. Informant Mrs. Caleb D. Rogers
Address Ellicott City Md

17. Burial Date thereof 5/2/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Mount
Location Baltimore, Md

18. Funeral director Wilson Col Son
Address 1217 E. Fort Ave

19. May 2 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1947, to April 30 1947 and that I last saw h[illegible] alive on April 30 1947

Immediate cause of death	DURATION
Chronic Cardio-Vascular-Renal Disease	27 yr.
Due to	
Due to	
Other conditions Senile dementia	6 mo

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D.
M. D. or other
Address Catonsville-28, Md Date signed 5/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45C)

00761

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Nine Years +

Hospital, institution, or street address where death occurred:
Rosewood State Training School

How long in hospital or institution? January 5, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rosewood State Training School
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Marion Mc Ginnis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Mahoney

6.(c) If alive, give age 44+ years

7. Birth date of deceased (mo., day, yr.) 2 - 28 - 1892

8. AGE:	Years	Months	Days	If less than one day
	55	1	12	11 hrs. 35 min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual occupation Chemist

11. Industry or business Davison Chem. Co - Employee

FATHER 12. Name Theodore Franklin Mc Ginnis

FATHER 13. Birthplace Baltimore City

MOTHER 14. Maiden name Margaret Ellen Fallon

MOTHER 15. Birthplace Brooklyn, New York

16. Informant Mrs. Edna M. Brown (Sister)

Address Rosewood State Training School

17. Cremat (Burial, cremation, or removal. Which?) Date thereof Apr 14-47 (month) (day) (year)

Cemetery or crematory Dominic

Location Woodlawn

18. Funeral director Stewart Morris Co.

Address 108 W Fayette Ave.

19. April 12 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947, at 11:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to April 10, 1947 and that I last saw h alive on April 10, 1947

Immediate cause of death	DURATION
Carcinoma of the Mouth	9 mos +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Viola Barrett Johns M.D.
M. D. or other

Address Rosewood St. Tr. School Date signed Apr 10 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-a)

00762

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:
300 Baltimore Avenue

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 300 Baltimore Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME
FRANK McLAUGHLIN

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Minnie Gardes

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): February 22, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	2	...hrs. ...min.

9. Birthplace: New Brunswick, New Jersey
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Tavern Keeper- Self

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. John Burton

Address: 300 Baltimore Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Baltimore, Maryland

18. Funeral director: John Burns Sons

Address: Towson, Maryland

19. Apr 27 1947 (Date rec'd by registrar) W. Darrell Kaylor Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24 1947 at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1947 to April 24 1947 and that I last saw h... alive on April 23 1947

Immediate cause of death	DURATION
Respiratory Failure	72 Hrs.
Due to: Left Cerebral Hemorrhage	7 Days
Due to: Arteriosclerosis	10 Yrs +
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Charles F. O'Donnell Md
M. D. or other

Address: 7301 York Rd Towson Date signed: 4/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

00763

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 8 months, 24 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 3 years, 8 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 125 S. Payson St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: MINNIE MEIER

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: Anton Meier
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): March 30, 1878

8. AGE: Years	Months	Days	If less than one day
69	—	13	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: August Koenig
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Redline
15. Birthplace: Germany

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-18-47 (month) (day) (year)
Cemetery or crematory: Oregon City
Location: Oregon City, Oregon
18. Funeral director: George L. Schwab
Address: 201 Frederick Avenue

19. 4-13-47 (Date rec'd by registrar) Harry H. Keefer Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12, 1947, at 10:05a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-12, 1947, to —, 19—, and that I last saw her alive on 4-12-, 1947.

	DURATION
Immediate cause of death: Fracture of femur	6 days
Due to: Arteriosclerotic Cardio vascular disease	Indef.
Due to: Acute exacerbation	
Other conditions: Chronic Cystitis	72 hours

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 4-6-'47
Where did injury occur? Spring Grove Hosp. (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Spring Grove Hosp.
Means of injury: Fell. Injured at work? No

23. SIGNATURE: D. D. Caples M.D. Med. Exam. (M. D. or other)
Address: Reisterstown, Md. Date signed: 4-12-47

VS A15 9-45 5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

B 00764

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BALTIMORE

City or town TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 4 mos. 8 days

Hospital, Institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or Institution? 6 yrs. 4 mos. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs. Ella Herbert Micou

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	divorced

6.(b) Name of husband or wife Benjamin Micou (deceased) 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4th 1869

8. AGE: Years	Months	Days	If less than one day
77	8	7	hrs. min.

8. Birthplace Montgomery, Alabama (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Hilliary A. Herbert

13. Birthplace Alabama

MOTHER 14. Maiden name Ella A. Smith

15. Birthplace Alabama

16. Informant HOSPITAL RECORDS

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-12-1947 (month) (day) (year)

Cemetery or crematory Rock Creek Cem

Location Washington D.C.

18. Funeral director Jos. D. Tickner & Sons

Address 1001 Pa. Ave. Balto (17) Md.

19. Apr 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 10 40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 3 1940, to April 11 1947

and that I last saw her alive on April 11 1947

	DURATION
Immediate cause of death Lobar pneumonia, bilateral	10 days
Due to senile involution	3 years
Due to generalized arterio sclerosis	17 years
Other conditions Psychosis with cerebral arteriosclerosis	7 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Lobar pneumonia, Arterio sclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. Elgin

W. W. Elgin, M. D. M. D. or other

Address TOWSON, MD. Date signed 4-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00765 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution~~, or street address where death occurred: 903 Bird River Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 903 Bird River Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nellie Broyles Mitchell **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Arless S. Mitchell 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30th 1947

8. AGE: Years	Months	Days	If less than one day
26	10	27	hrs. min.

9. Birthplace Chuckey Tenn. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name George R. Broyles
13. Birthplace Tenn.

MOTHER
14. Maiden name V. Green
15. Birthplace Tenn.

16. Informant Arless S. Mitchell
Address Hq. Co. 2nd Army Fort Meade Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/2/47 (month) (day) (year)
Cemetery Andrew Johnson National Cemetery
Location Greenville Tenn.

18. Funeral director William Cook Inc.
Address 127 E. Paul St.

19. May 2 1947 (Date rec'd by registrar) A. W. Pedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 30 1947 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Gun shot wound Left Chest (close range)	Immediate
Due to	
Due to 6 mo. Pregnant.	
Other conditions 32 Cal. Pistol. (Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 4/30/47
Where did injury occur? Middle River Balto. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Pistol bullet Injured at work? No

23. SIGNATURE J. M. Learmonth M.D. Deputy Medical Examiner (To be signed by attending physician or coroner)
Address Dundalk Md. Date signed 4/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 00765

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 26 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glenburnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 209 Third St., S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3. (a) FULL NAME: DRUSCELLA ROSE MOORS

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife: Thomas Moors
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 28, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	24	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: John Shearer
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Lillian Murphy
15. Birthplace: Washington, D.C.

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof April 25 47 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md

18. Funeral director: Thomas W. Pinkston
Address: Glen Burnie, Md

19. 4-29-47 (Date rec'd by registrar) Harry A. Mullen (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 47 at 10:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 19 47 to April 23 19 47 and that I last saw her alive on April 23 19 47

Immediate cause of death	DURATION
Meningitis	24 hours
Due to: Carcinoma of left breast, metastasis.	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
Address: Catonsville 28, Md. M.D. Date signed: 4/24/47

VS A15 9-45 5M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

00767

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Garrison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? -
Hospital, institution, or street address where death occurred:
Reisterstown Road
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Gwynnbrook Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Guy Moser

3.(b) Social Security Number: 215-22-3158

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Florence Merryman Moser
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): December 2 1895

8. AGE:	Years	Months	Days	If less than one day
	51	4	20	...hrs. ...min.

9. Birthplace: Creagerstown Frederick Co Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -

FATHER
12. Name: Charles David Moser
13. Birthplace: Frederick Co Md

MOTHER
14. Maiden name: Belle Eby
15. Birthplace: Blue Ridge Summit Md

16. Informant: Roy Moser
Address: Gwynnbrook Ave Owings Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 - 25 - 47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville Md

18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. 4 - 23 - 47 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-22- 1947, to 4-22 1947 and that I last saw h... alive on ... not ... 1947

Immediate cause of death	DURATION
Fractures of base of skull	
Fractured mastoid Left side	2 hours
Due to: Fractured base	
Fractured Pelvis - Left side	
Due to: Fractured Left Clavicle	
Fractured Left Ankle	
Other conditions: Multiple Lacerations of scalp & Left Lumbar	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 4-22-47
Where did injury occur? Gwynnbrook (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Highway Road
Means of injury: Automobile Accident Injured at work? No

23. SIGNATURE: D. D. Caples, M. D. med. exam
M. D. or other
Address: Reisterstown, Md. Date signed: 4-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00768 P

CERTIFICATE OF DEATH

Reg. Dist. No. 32

M

1947
1873
74

47
74
65

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
7004 Plymouth Rd.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 842 W Lexington Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Jacob John Oster

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Minnie
6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Nov. ~~Oct~~ 9, 1873

8. AGE: Years	Months	Days	If less than one day
73	4	28	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation cigar maker
11. Industry or business —

FATHER
12. Name Jacob Oster
13. Birthplace Germany

MOTHER
14. Maiden name Catherine Conrad
15. Birthplace Germany

16. Informant Mrs. Mamie Houser
Address 7004 Plymouth Rd. Pikesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 4/9/47 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md
18. Funeral director Tallhorn & Son Inc
Address 1219 E Fort Ave

19. 4/8 19 47 (Date rec'd by registrar) D.W. Frederick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 April 19 47 at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 April 19 47 to 7 April 19 47 and that I last saw h.i.m. alive on 6 April 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	
(with left hemiplegia)	
Due to hypertension C.V.D.	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles H Williams M. D. or other
Address Pikesville, Md. Date signed 7 April 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00769

Reg. Diat. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Hood Nursing Home

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2013 W. Lexington St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Virginia Platt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ late Mathew Alexander

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1860

8. AGE:

Years	Months	Days	If less than one day
86	8	32	hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thomas Carey

13. Birthplace

MOTHER 14. Maiden name Susan

15. Birthplace

16. Informant Mrs Milton Platt

Address 2013 W. Lexington St

17. Buried Date thereof April 17, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18. Funeral director Harry H Wetzler

Address 4101 Edmondson Ave

19. 4-13- 1947 Harry D. Muller Deputy Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/16 1947 to 4/10 1947

and that I last saw h... alive on 4/10/47 1947

Immediate cause of death	DURATION
Terminal Hypostatic Pneumonia	2 Weeks
Due to Cardio-Vascular Disease & Decompensation	3 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elliot W Johnson M. D. or other

Address 3432 Frederick Ave Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72c)

CERTIFICATE OF DEATH

00770

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore,
City or town: Catonsville,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore,
City or town: Catonsville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 Wyndcrest Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles E. Poor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Irene N. Nicewaner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1868

8. AGE: Years	Months	Days	If less than one day
79	3	29	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER — 12. Name: Charles O. Poor
13. Birthplace: Balto. Md.

MOTHER — 14. Maiden name: Mary Ann Stewart
15. Birthplace: Va.

16. Informant: Mrs. Irene N. Poor
Address: 16 Wyndcrest Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1947 (month) (day) (year)
Cemetery or crematory: Green Mount Cemy.
Location: Baltimore, Md.

18. Funeral director: John O. Mitchell & Sons
Address: 1900 Eutaw Place

19. 5-1- 1947 (Date rec'd by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1947 at 3.17 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 6 1947, to April 30 1947
and that I last saw him alive on April 30 1947

	DURATION
Immediate cause of death: Myocardial Insufficiency	3 wks.
Due to: Chr. Rheumatic Endocarditis	25 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D. M. D. or other
Address: 6209 Fredericksburg Date signed 5-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 954

00771 P

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County BALTIMORE Co.
City or Town LANSDOWNE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
155 HOWARD AVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County BALTIMORE
City or town LANSDOWNE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 155 HOWARD AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARGARET ELIZABETH POPPHAM

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife HENRY M. POPPHAM
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) MARCH 10, 1891

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace BALTIMORE CO. (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
FATHER 12. Name CHARLES W. HELWIG
13. Birthplace BALTIMORE CO.
MOTHER 14. Maiden name CATHERINE NINE
15. Birthplace BALTIMORE CO.
16. Informant HENRY M. POPPHAM
Address 155 HOWARD AVE
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4 (month) 24 (day) 47 (year)
Cemetery or crematory LOUDON PARK
Location FREDERICK RD
18. Funeral director JOHN F. DENNY, INC.
Address 715 LIGHT ST.
19. 4/24/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22, 1947, at 6.00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1941 to Apr 22 1947
and that I last saw h[illegible] alive on Apr 22 1947

Immediate cause of death	DURATION
Rheumatic Heart Disease	?
Due to	
Due to	
Other conditions Auricular Fibrillation & congestive heart failure	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Carl P. Rostberg M. D. or other
Address 326 W. Lombard St. Date signed 4/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Carl P. Roetling.
1326 W. Lombard St.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00772

(55)

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 34

Village or City White House No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Carrie Olive Powell

(a) Residence: No. White House, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lee Alexander Powell

6. DATE OF BIRTH (month, day, and year) Feb 10 1901

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Housekeeping

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Rutherfordton, N.C. (State or country)

FATHER

13. NAME Stephen A. Ellis

14. BIRTHPLACE (city or town) McDowell Co. N.C. (State or country)

MOTHER

15. MAIDEN NAME Bruciella Bright

16. BIRTHPLACE (city or town) McDowell Co. N.C. (State or country)

17. INFORMANT Rev. Lee Alexander Powell (Address)

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Charlotte Co. N.C. Date May 2nd, 1947

19. UNDERTAKER Edw. A. Lipton (Address) Hyattsville Md.

20. FILED April 30, 1947 Cyril E. Fowble M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 30 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 31, 1947, to April 30, 1947

I last saw her alive on April 29, 1947; death is said to have occurred on the date stated above, at 4:10 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cancer primary of dorsal Spine, Thence metastasis of Stomach, uterus, and lungs	1943
Other Contributory Causes of importance: Asthenia, starvation from vomiting food	Feb. 1947

Name of operation: Breast amputation Date of Apr. 17, 1941

What test confirmed diagnosis? Hospital X-rays Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Cyril E. Fowble M. D.

(Address) Hyattsville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00773

(44a)

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred: 8 Church Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Church Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: HARRY TRUMAN PURDUM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret S. Purdum

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 24, 1879

8. AGE: Years	Months	Days	If less than one day
67	3	12	hrs. min.

9. Birthplace: Montgomery County, Md. (Town, county, and state)

10. Usual occupation: Ass't Postmaster

11. Industry or business: Baltimore City

FATHER — 12. Name: Thomas Purdum

FATHER — 13. Birthplace: Montgomery Co., Md.

MOTHER — 14. Maiden name: Emma Lewis

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Margaret S. Purdum

Address: 8 Church Lane, Pikesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 - 8 - 47 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cem.

Location: Pikesville, Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: Baltimore, Md.

19. 4 - 7 - 47 (Date rec'd by registrar) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947 at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 28, 1945 to April 6, 1947

and that I last saw him alive on April 4, 1947

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to: Arterial hypertension	
Due to:	
Other conditions: Coronary Artery disease	Oct. 1945

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E E Nichols M. D. or other

Address: Pikesville, Md. Date signed: 4/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

Reg. Dist. No. 01774

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since March 27, 1947
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since March 27, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1606 Wilkins Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary M Calston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: James W Calston
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): April 7, 1904

8. AGE: Years: 43 Months: 0 Days: 7 If less than one day: hrs. min.

9. Birthplace: St Mary's County, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Truett
13. Birthplace: St Mary's County, Md

MOTHER
14. Maiden name: Lydia Dean
15. Birthplace: St Mary's County Md

16. Informant: Personal History- Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: April 18-1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto, Md

18. Funeral director: Pratt C and B.M. Walters
Address: Pratt & Stricker Sts

19. (Date rec'd by registrar) April 16 1947 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1947, to April 14 1947
and that I last saw h.. alive on April 14 1947

	DURATION
Immediate cause of death: Pulmonary tuberculosis	time about last 1941
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W C Bridges M. D. or other
Address: Towson 4, Maryland Date signed: 4-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. [redacted] 20 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Catonsville
(b) Street address 5501 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 60775
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 S. Cornwall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathilda Raynor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife James E. T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1878

8. AGE: Years	Months	Days	If less than one day
68	11	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick Kattenhorn
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Steinberger
15. Birthplace Germany

16 (a) Informant James E. T. Raynor
(b) Address 429 S. Cornwall St.

17 (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 [redacted] (b) Registrar William [illegible]
(Date rec'd by registrar)
April 16, 1947 A. W. Fedrick

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to April 16 1947, and that I last saw h alive on April 16 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	2 days
Due to C.A. of Stomach	1½ yr
Due to Metastasis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 1946
Major findings of operation: CA of Stomach
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Lewis Stowell M. D.
Address Catonsville Date signed 4-18-47

VS A15 9-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54a)

CERTIFICATE OF DEATH

00776

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Lou Ann Rea

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 28, 1928

8. AGE: Years	Months	Days	If less than one day
18	8	6	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: College

FATHER
12. Name: Mellan Rea
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Elsie Malcin Rea
15. Birthplace: Pocomoke City, Md.

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3 April 1947 (month) (day) (year)

Cemetery or crematory: Hyattsville Md.

Location: Hyattsville Md.

18. Funeral director: J. Barcla Conn.

Address: Hyattsville Md.

19. 4-3- (Date rec'd by registrar) 1947 Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1947, at 9:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1947, to April 3 1947 and that I last saw her alive on April 3 1947

Immediate cause of death	DURATION
Brain tumor; malignant, arising from the subependymal plate.	indef'
Due to: Cerebral edema Cyst 3.0.	indef
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed 4-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

00777p

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3626 Forest Hill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3626 Forest Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John H. Reich

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sadie Z. Reich
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 28, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	27	..... hrs. ..... min.

9. Birthplace Catonsville, Md. (Town, county, and state)
10. Usual occupation Retired Assistant Treasurer
11. Industry or business C. D. Kenny Co.

FATHER
12. Name Henry J. Reich
13. Birthplace Germany

MOTHER
14. Maiden name Margaret Hagen
15. Birthplace Maryland

16. Informant Mr. Edwin H. Reich
Address 3602 Forest Hill Road, Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28, 1947 (month) (day) (year)
Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18. Funeral director E. Willis Lamoreaux
Address 4510 Liberty Heights Ave.

19. April 28 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947, at 2.30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1940, to April 1947
and that I last saw him alive on April 24 1947

Immediate cause of death	DURATION
Carcinoma of ascending colon with generalized metastases	1yr?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Jesse A. Kochman, MD M. D. or other
Address Main & Forest Sts. Ellicott City, Md. Date signed 4/26/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06778

Reg. Dist. No. 40

1. PLACE OF DEATH
County: Balto Co.
City or town: Kingsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles A. Rest

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

B.(b) Name of ~~husband~~ or wife: Mary C. Rest
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2 - 1887

8. AGE: Years: 60 | Months: 2 | Days: - | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Insurance Agent.

11. Industry or business

FATHER 12. Name: Franklin D. Rest
13. Birthplace: Md.

MOTHER 14. Maiden name: Mary A. Armacost
15. Birthplace: Md.

16. Informant: Mrs Mary C. Rest
Address: Kingsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12-47 (month) (day) (year)
Cemetery or crematory: St. Johns Kingsville Md
Location: Kingsville Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md.

19. April 11 1947 (Date rec'd by registrar) C. E. Arthur Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1947, at 6:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3 1945 to April 10 1947
and that I last saw h alive on April 9 1947

	DURATION
Immediate cause of death: (a) Primary Thrombosis	3 MIN.
Due to: Coronary Sclerosis	18 YRS
Due to: Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Clifford F. Anderson M.D.
M. D. or other
Address: Fork Md. Date signed 4/11/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00779 P

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore,
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore,
City or town: Owings Mills,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Orchard Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Dr. William B. Rider

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Kate A. Bateman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1858

8. AGE: Years	Months	Days	If less than one day
89	2	9	hrs. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Physician
11. Industry or business

FATHER
12. Name: Edward Rider
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Rebecca A. McConkey
15. Birthplace: Balto. Co. Md.

16. Informant: Miss Mildred Rider
Address: Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/47 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemy.
Location: Pikesville, Md.

18. Funeral director: John O. Mitchell Funeral Home
Address: 1900 Eutaw Place Balto. Md.

19. April 16 19 47 (Date rec'd by Registrar) A. W. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1947, at 7.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-20 1943, to 4-14 1947
and that I last saw him alive on 4-12 1947

Immediate cause of death	DURATION
Coronary Occlusion	5 min.
Due to	
Due to	
Other conditions: Pernicious anemia	7 yrs.
arthritis	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) None (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. D. Caples, M.D. M. D. or other
Address: Reisterstown Md. Date signed 4-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06780

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Balto
City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)
Street No. Belair Rd near Joppa Rd. (If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Frank Hartshorn Robinson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Agnes Rollins
6.(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) Nov. 25. 1869

8. AGE: Years 77 | Months 4 | Days 14 | If less than one day ... hrs. ... min.

6. Birthplace Harford County Md. (Town, county, and state)
10. Usual occupation Bridge Carpenter
11. Industry or business Penna R.R. - Retired 10 yrs.

FATHER
12. Name Thomas Robinson
13. Birthplace Md

MOTHER
14. Maiden name Elizabeth Swift
15. Birthplace Md.

16. Informant Mrs. Agnes Robinson
Address Belair Rd near Joppa Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 11, 1947 (month) (day) (year)
Cemetery or crematory Cokesbury Mem. Cemetery
Location Abingdon - Md.

18. Funeral director Henry Sander & Sons Inc.
Address North Ave & Broadway. Balto. 13, Md.

19. 4/11 1947 A.W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947 19... at 3.05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1947, to April 8 1947
and that I last saw h... alive on April 8 1947

	DURATION
Immediate cause of death Coronary Thrombosis	14 hrs.
Due to Coronary Sclerotic Heart Disease	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M. D. or other
Address Fork, Md Date signed 4/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00781 B

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County 617 Avondale Rd South

City or town Turners Sta. Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For oeborn infants give resideoce of mother)

State Md County Baltimore

City or town Turners Sta Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Avondale Rd, Dundalk 22 Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bertha Elizabeth Rowles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Reginald Roles

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Oct 22 - 1922

8. AGE: Years	Months	Days	If less than one day
25			..... hrs. ..... min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Bernad Cox

13. Birthplace Lancaster Co Va

MOTHER

14. Maiden name Carrie Conway

15. Birthplace Northumberland Co

16. Informant Mr Reginald Roles

Address 6175 Avondale Road Turners Station

17. Buried

(Burial, cremation, or removal. Which?) Date thereof 4-8-47 (month) (day) (year)

Cemetery or crematory Arbutus Memorial Park

Location Baltimore County Md

18. Funeral director Mrs George H. Holland

Address 631 Grindhill Ave, Balto Md

19. 4/8 19 47 J. W. Bedsul Registrar

(Date rec'd by registrar)

DA

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1947 19 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2nd 1947 to April 4th 1947

and that I last saw he alive on April 4th 1947 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. V. Thomas M.D.

M. D. or other

Address Turners Sta Md Date signed 5/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00782

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Approximately 45 Minutes
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? Approximately 45 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1927 E. Pratt Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: JOHN RUTH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-24-96

8. AGE: Years	Months	Days	If less than one day
50	7	21	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

FATHER
12. Name: Jacob Ruth
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mollie Herbick
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/19/47 (month) (day) (year)
Cemetery or crematory: Trinity
Location: O'Donnell Street
18. Funeral director: Libby & Zeiler, Inc.
Address: 403 S. Wolfe Street

19. 4/16 19 47 (Date rec'd by registrar) G.W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1947 to April 15, 1947 and that I last saw him alive on April 15, 1947

Immediate cause of death	DURATION
Heart disease, hypertensive and	
Coronary arteriosclerosis with	
myocardial failure.	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIRECTOR (Attending physician, coroner)
Address: V.A., FORT HOWARD, MD. Date signed: 4-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 1866 Reg. Dist. No. 44 B 00783

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
(a) County Bello.
(b) City or town Sparrows Point.
(If outside city or town limits, write RURAL and give town)
(c) Street address, Hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Stromeyer Lane
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Rzasa. (RZASA)

3 (b) If veteran, name war

3 (c) Social Security No. 172-03-7023

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Stella -

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1893

8. AGE: Years 53 Months 10 Days If less than one day hr. min.

9. Birthplace Poland.
(Town, county and state)

10. Usual occupation Brick Layers Helper

11. Industry or business Bethl. Steel Corp.

FATHER
12. Name Martin Rzasa
13. Birthplace Poland.

MOTHER
14. Maiden Name Lucia Rzeszatch
15. Birthplace Poland.

16 (a) Informant Helen Rzasa
(b) Address 1419 Stromeyer Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/31/47 (month) (day) (year)
(c) Cemetery or crematory
Location Hunstown Pa.

18 (a) Funeral director John A. Moran
(b) Address 3000 E. Balto St

19 (a) April 28 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. Date of death April 26 1947, at 10.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw him alive on 19.

Immediate cause of death Complete Evisceration
Due to Crushed Left Pelvis
Due to Crushed between 2 cars
Other conditions (Not an auto. acc.)
(Include pregnancy within 3 months of death)

Duration: Immediate

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 26 1947
(c) Where did injury occur? Sparrows Pt. Balto. Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial While at work? Yes.
(Specify type of place)
(e) Means of injury Crushed between 2 cars.

23. Signature L. T. McCormick M. D.
M. D. or other
Address Dundalk. Md Date signed 4/26/47.

VS. A15

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

P 0784

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Dogwood Road

How long in hospital or institution? 35 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dogwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Wesley Sauter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie E. Sauter

B.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 8, 1866

8. AGE:

Years	Months	Days	If less than one day
81	1	18	....hrs. ....min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Self

FATHER
12. Name: Julius Sauter
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Thomas
15. Birthplace: Baltimore County, Md.

16. Informant: Mrs. Maggie Sauter

Address: Dogwood Road, Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown

18. Funeral director: E. Miller Lamoreau

Address: 4510 Liberty Heights Ave.

19. April 28 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 19 47, at 2.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 19 47 to Apr 26 1947 and that I last saw him alive on Apr 24 1947

	DURATION
Immediate cause of death: Myocarditis	1 Year
Due to: Arteriosclerosis	1 Year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. C. Lamoreau M. D. or other

Address: 4509 Liberty Hgts Ave. Date signed: Apr 28 45

M

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T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Bacon 2801 Taylor Ave.

00785

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Carney
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Months
Hospital, institution, or street address where death occurred:
9301 Harford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9301 Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Stephanie S. Schleisener

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 20, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	2	hrs. min.

9. Birthplace: Baden-Baden Germany
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Fredolin Staub
13. Birthplace: Germany
MOTHER 14. Maiden name: Franciska Krumm
15. Birthplace: Germany
16. Informant: Mrs. Louise Baake
Address: 9301 Harford Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25,1947 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Parkville, Maryland
18. Funeral director: William Cook, Inc.,
Address: 1217 St. Paul Street
19. 4/24 19 47 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 19 47 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 17 19 47 to April 22 19 47 and that I last saw h[illegible] alive on April 19 19 47

Immediate cause of death: Chr. myocarditis, mitral regurgitation, chronic nephritis	DURATION: 5 yrs +
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. M. Bacon M.D. M. D. or other
Address: 2810 Taylor Ave. Date signed: 4/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00786 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore Highlands (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore Highlands (If outside city or town limits, write RURAL and give nearest town)
Street No. 2811 Ohio Avenue (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wilhelmina Paulina Schrodetzki

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William F. Schrodetzki 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 29 1860

8. AGE: Years	Months	Days	If less than one day
86	7	4	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Retired Housewife
11. Industry or business
FATHER 12. Name: John Radke
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Germany
16. Informant: Amelia A. Logis
Address 2811 Ohio Avenue
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md.
18. Funeral director: George L. Schwab
Address 2101 Frederick Ave
19. April 3 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1947 at 8:10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1947 to April 2 1947 and that I last saw her alive on March 30, 1947

Immediate cause of death	DURATION
Acute Myocardial Insufficiency	3 hours
Due to: Cerebral Hemorrhage & Metastases	8 mos.
Due to: Generalized Arteriosclerosis	?
Due to:	
Other conditions: Diabetes Mellitus	3 yrs
Incipient Arteriosclerotic Gangrene Legs	2 mos

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Earl Jaso, M.D. (M. D. or other)
Address 4001 Wilkens Ave Date signed 4-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

00787 P

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 22 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 5 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 316 South Lehigh Street
(If rural, give LOCATION)

2.(a) If veteran, name war: W

3. (a) FULL NAME: Catherine Schrodel (Schroedel)

3. (b) Social Security Number: W

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Frank Schroedel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 2, 1862

8. AGE: Years	Months	Days	If less than one day
84	4	6	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, ~~cremation, or removal, Which?~~) Date thereof 4-12-47 (month) (day) (year)

Cemetery or ~~crematory~~: Mt. Maria

Location: Towson Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul st.

19. 4/11/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 19 47, at 4:55 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 19 46, to April 8 19 47 and that I last saw h...er alive on April 8 19 47

Immediate cause of death	DURATION
Gangrene of right foot	1 week
Due to: Generalized arteriosclerosis	indefinite
Due to: Amaurosis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 4-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00788 P

(61)

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Parkville,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County Baltimore

City or town Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3003 Lavender Ave.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha Schulze

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Henry Schulze

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) August 25, 1872

8. AGE: Years	Months	Days	If less than one day
74	7	19	hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name Franz Portuis

13. Birthplace Germany

MOTHER 14. Maiden name Amelia

15. Birthplace Germany

16. Informant Mrs. Ida Renner

Address 7811 Ardmore Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16, 1947 (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore, Md.

18. Funeral director Ullrich Funeral Home

Address 2008 Orleans St.,

19. April 15 19 47 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947 19 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to April 14 19 47

and that I last saw h E.R. alive on April 13, 19 47

	DURATION
Immediate cause of death Bronchio-pneumonia	2 days
Due to Arteriosclerotic Heart Disease	5 years
Due to Diabetes Mellitus	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Renner M. D. or other

Address 4808 Harford Rd. Date signed 4/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00789

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Camp Mills, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs 2 mos 25 days

Hospital, Institution, or street address where death occurred:
Rosewood 6 yrs 2 mos 25 days

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Eastern, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Carroll Erdmin Schwaninger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29, 1929

8. AGE: Years 17 | Months 9 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Eastern, Harford Co., Md
(Town, county, and state)

10. Usual occupation Inmate, Rosewood State

11. Industry or business Training School

FATHER
12. Name Erdmin A. Schwaninger
13. Birthplace Eastern, Md

MOTHER
14. Maiden name Mildred L. McQuay
15. Birthplace Bozman, Md

16. Informant Institutional records
Address Camp Mills, Md.

17. Burial (Burial, cremation, or removal) Date thereof Apr 21 47 (month) (day) (year)

Cemetery or crematory Harwood Cemetery

Location Cardova, Md.

18. Funeral director Stewart Mortuary Co.

Address 108 W. North Ave.

19. 4/19/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 April 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 1947, to 17 April 1947 and that I last saw h... alive on 17 April 1947

Immediate cause of death	DURATION
Bronch. Pneumonia	2 da
Due to Acute Bronchitis	3 "
Due to Salmonella Infection (Gastro-enteric type)	2 "
Other conditions Liver Disease	Bert

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Harry G. Bubley M.D.
M. D. or other

Address Camp Mills, Md Date signed 4/17/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48.6)

CERTIFICATE OF DEATH

00790 37

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparks (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred: Quaker Bottom Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Sparks (If outside city or town limits, write RURAL and give nearest town)
Street No.: Quaker Bottom Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Cordelia Scott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negroe	Married

6.(b) Name of husband or wife: Edward Marion Scott
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): December 11, 1900

8. AGE: Years: 46 Months: 4 Days: 11 If less than one day: hrs. min.

9. Birthplace: Baltimore, Balt. Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Louis Wesley Whye
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Anna Louisa Smith
15. Birthplace: Frederick Co. Md.

16. Informant: Mary Grace Cromwell
Address: Post Office Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-25-47 (month) (day) (year)
Cemetery or crematory: Vernon Chapel
Location: Monkton, Md.

18. Funeral director: London M. Brooks
Address: Sparks, Md

19. 4-24 1947 Wilmer C. Ensor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 April 1947 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 March 1947 to 22 April 1947 and that I last saw h.er alive on 22 April 1947

Immediate cause of death	DURATION
Cancer of the uterus	3 yrs
Due to	
Due to	
Other conditions: Anemia 2°	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kees M. D. (M. D. or other)
Address: Cockeysville, Md. Date signed: 4-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

00791

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 40 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1141 Ridgley Street

(If rural, give LOCATION)

2.(a) If veteran, name war SAW

3.(a) FULL NAME

GEORGE SCOTT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hazel Scott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-5-77

8. AGE: Years	Months	Days	If less than one day
69	10	4	..... hrs. ..... min.

9. Birthplace Orell, Ky.

(Town, county, and state)

10. Usual occupation Retired Guard

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Kentucky

MOTHER 14. Maiden name Elizabeth McNutt

15. Birthplace Kentucky

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof April 22, 47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto. National Mem.

Location Frederick Ave.

18. Funeral director Joseph T. Ambuce, Jr.

Address 416 N. Franklintown Rd.

19. 4/21 1947 J. W. Hedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1947 to April 19, 1947 and that I last saw him alive on April 19, 1947

Immediate cause of death	DURATION
Carcinoma of the Colon with metastasis to the liver and regional	157 Days plus.
Due to: lymph nodes	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR. or other

Address V.A.H. FORT HOWARD, M.D Date signed 4-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

00792 38

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Hillendale Park Baltimore 14
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs.
Hospital, Institution, or street address where death occurred: Parkville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Hillendale Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1702 Goodview Road
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Wilmer Bernard Shanahan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret L. Shanahan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1900

8. AGE: Years	Months	Days	If less than one day
46	6	13	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Retired Patrolman
11. Industry or business

FATHER
12. Name John Shanahan
13. Birthplace

MOTHER
14. Maiden name Margaret
15. Birthplace

16. Informant Margaret L. Shanahan
Address 1702 Goodview Rd.
17. Burial Date thereof April 8, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Maryland
Location Baltimore, Maryland
18. Funeral director Leonard J. Ruck
Address 5305 Harford Rd, Baltimore
19. 4-8 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19.. to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion, sudden	4/5/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Rollin C. Hudson M.D. D.M.E.
M. D. or other
Address Towson 4 Md. Date signed 4/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00793 P

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town College Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4807 Guilford Road
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Elizabeth Sherwood

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Ira Sherwood
deceased 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) October 26, 1871

8. AGE: Years	Months	Days	If less than one day
75	5	30	... hrs. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name Nicholas Rewer

13. Birthplace Germany

MOTHER 14. Maiden name Mary Ellinghaus

15. Birthplace Germany

16. Informant Hospital records

Address Catonsville, 28, Md.

17. Burial Date thereof 4/28/47
(Burial, ~~cremation, or removal~~. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ Cathedral

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 127 St. Paul St

19. 4/26-47 (Date rec'd by registrar) 19 A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947 19 ... at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1947 19 ... to April 25, 1947 and that I last saw her alive on April 25, 1947 19 ...

	DURATION
Immediate cause of death Chronic myocarditis	Indefinite
Due to Interstitial nephritis	"
Due to	
Other conditions Abscess left mandible alveolar	1 week

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.
M. D. or other

Address Catonsville, 28, Md. Date signed 4/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

00794

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore County
City or town: ~~Baltimore — rural~~ Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MO.
Hospital, institution, or street address where death occurred:
Hood Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3405 Southern Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CLARA JEANETTE SHIMP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Jacob L. Shimp
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1860

8. AGE: Years	Months	Days	If less than one day
86	11	1	hrs. min.

9. Birthplace: Penna
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Jesse McMullen
13. Birthplace: Penna

MOTHER
14. Maiden name: Barbara Plasterer
15. Birthplace: Penna

16. Informant: Mrs. WM. Kehs
Address: 3203 Rosekemp Avenue

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 4/22/47
(month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Manheim, Pa.

18. Funeral director: HENRY SANDER & SONS, INC
Address: NORTH AVE. & BROADWAY

19. 4/21 47 A.W. Hedrick Dr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH: April 20, 1947 at 10.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1, 19 47, to Apr. 20 19 47
and that I last saw h[illegible] alive on Apr 20 19 47

Immediate cause of death	DURATION
Cardiac Failure	2 days
Due to: Cerebral Arteriosclerosis	
Telebrosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jesse Rutowski M. D. or other
Address: [illegible] Date signed 4-21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(940) 00795 P

Reg. Diat. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 58 S. Dundalk Ave
How long in hospital or institution? 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5-8 S. Dundalk ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Alfred Shorney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Johanna
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22 - 1893

8. AGE: Years	Months	Days	If less than one day
53			..... hrs. ..... min.

9. Birthplace New York State
(Town, county, and state)
10. Usual occupation Steel Worker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Joseph Holler
Address 58 S Dundalk Avenue

17. ~~Oak Lawn~~ Burial Date thereof 4/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Dundalk Ave & R.R.
18. Funeral director Selby & Zader, Inc
Address 403 S. Wolfe St.

19. 4/11 19 47 C.W. Hedrick M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 19 47 to Apr 10 19 47 and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J M Clemmine M.D.
M. D. or other
Address Dundalk Md Date signed 4/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

00796

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (551)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
207 E. Joppa Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 207 E. Joppa Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3. (a) FULL NAME: MARGARET ELIZABETH SKIDMORE

3. (b) Social Security Number: ******

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Higbie Skidmore
6.(c) If alive, give age: ——— years
7. Birth date of deceased (mo., day, yr.): June 12, 1880

8. AGE: Years	Months	Days	If less than one day
66	10 9	23	....hrs. ....min.

9. Birthplace: Milroy, Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Joseph Spotts Henning
13. Birthplace: Kelly Township, Penna.

MOTHER
14. Maiden name: Mary Elizabeth Rupp
15. Birthplace: Selinsgrove, Penna.

16. Informant: Margaret Dale Skidmore
Address: 207 E. Joppa Rd., Towson, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof April 23, 1947 (month) (day) (year)
Cemetery or crematory: Murtfeld and Calver, Inc.,
Location: Newburgh, N.Y.
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. Apr 21 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1947, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 39 to 20 April 1947 and that I last saw h.e.r. alive on 19 April 1947

Immediate cause of death	DURATION
Carcinomatosis	
Due to Metastasis from kidney	
Due to	
Other conditions Chronic Cholecystitis & Lithiasis Terminal hypostatic Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: Carcinomatosis - general
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert W. Deeming M. D. or other
Address: 4 Bellevue St. Towson 4 Date signed: 21 April 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

00797 8

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH

County Balto.

City or town Cupeston P.O Balto #6

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

705 Elmwood Ave

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Balto City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5501 Park Heights Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles H. Smith.

3.(b) Social Security Number 213-09-7513

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary T.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 2 - 1875

8. AGE: Years 72 | Months 1 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation

11. Industry or business Janitor

FATHER 12. Name Chas. E. Smith

13. Birthplace Baltimore

MOTHER 14. Maiden name ?

15. Birthplace ?

16. Informant Mrs. Mary T. Smith

Address 4137 Mary Ave

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4 24 47 (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore

18. Funeral director Philip Herwig Sons

Address 2024 Orleans St

19. 4/23 1947 (Date rec'd by registrar) L.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 21 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Coronary occlusion 3 min

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. McCormick M.D. M. D. or other

Address Dept. Medical Examiner Baltimore Md Date signed 4/24/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (521)

CERTIFICATE OF DEATH

06798

Reg. Diat. No. 30

50

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1105 Symington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clara W. Soldan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-22-1873

8. AGE: Years: 74 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Home

FATHER
12. Name: John Langdorf
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Amalia Thomas
15. Birthplace: Germany

16. Informant: Clarence Soldan
Address: 1105 S. Symington Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-29-47 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18. Funeral director: Edw. L. MacNabb
Address: Catonsville, Maryland

19. 4-29 1947 (Date rec'd by registrar) Harry L. Walker Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1947 at 11:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1943, to April 26 1947 and that I last saw him alive on April 25 1947

Immediate cause of death	DURATION
Metastatic Ca of Rectum + Vagina	1 yr.
Due to: Ca of Bladder	3 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wilson K. Gallagher M.D. M. D. or other
Address: Catonsville-28, Md. Date signed 4/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

CERTIFICATE OF DEATH

00799

Reg. Dist. No. 39

1. PLACE OF DEATH:

County: Baltimore

City or town: Baldwin (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sweet Air (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baldwin P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Jennie Waters Sollenberger

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Apr. 25, 1941

8. AGE:

Years	Months	Days	If less than one day
5	11	25	hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER — 12. Name: McCord Sollenberger

FATHER — 13. Birthplace: Balto. Md.

MOTHER — 14. Maiden name: Katherine Abercrombie

MOTHER — 15. Birthplace: Balto. Md.

16. Informant: Mrs. McC. Sollenberger

Address: Baldwin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 21, 1947 (month) (day) (year)

Cemetery or crematory: Trinity

Location: Long Green, Md.

16. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Apr. 20, 1947 (Date rec'd by registrar) Emma Price, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 19, 1947, at 3 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...

and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Compound, Comminuted fracture of skull	
Due to: Struck by automobile	
Due to:	
Other conditions: Fracture of both femurs	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 4/19/47

Where did injury occur? (City or town) Balto. (County) Co. (State) Md.

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Struck by automobile Injured at work? No

23. SIGNATURE: G. M. France, M. D. or other

Address: Parkton, Md. Date signed: 4/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06800

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Middle River - 21

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1628 Dartford Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bessie Sonner.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec. 8 Oct 1902

8. AGE:

Years	Months	Days	If less than one day
44	4	10	...hrs. ...min.

9. Birthplace: Toledo N. C. (Town, county, and state)

10. Usual occupation: Cafeteria

11. Industry or business: Mort. Bon. Work

FATHER

12. Name: Quentin C. Jones

13. Birthplace: N. C.

MOTHER

14. Maiden name: Ettie Farrell

15. Birthplace: S. C.

16. Informant: Samuel Sonner

Address: 19 Bluster St. Balto 20.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Apr. 18 1947 (month) (day) (year)

Cemetery or crematory: Mountain Page

Location: Mark Carmichael

18. Funeral director: John J. Connelly

Address: 1 E. Eastern Ave

19. ... 19... John J. Connelly (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 19 47, at 9:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Carbon Monoxide Poisoning	
Due to: Gas - Illuminating.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 4-18-47

Where did injury occur: Middle River 21 - Balto Co. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Inhaled Illuminating Gas Injured at work?

23. SIGNATURE: M. Bowers M.D. Medical Examiner, (M.D. or other)

Address: ... Date signed 4-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

00801 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
5313 Edmondson Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1405 Orch Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary B. Sparks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife George T. Sparks
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 3-1875

8. AGE: Years	Months	Days	If less than one day
72	2	19	..... hrs. ..... min.

9. Birthplace Queen Annes Co. Maryland
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Thomas Carey
13. Birthplace Maryland
MOTHER 14. Maiden name Frances Lane
15. Birthplace Maryland
16. Informant Mrs. James L. Marr
Address 1327 N. 40th St. Baltimore
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24-1947 (month) (day) (year)
Cemetery or crematory Chesterfield
Location Centreville, Maryland
18. Funeral director Burgee Funeral Home
Address 3631 Falls Road, Baltimore
19. April 22 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 47, at 4 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 3 19 47 to Apr 22 19 47
and that I last saw h.r alive on Apr 22 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	10 days
Due to Arterio Sclerosis	
Cancer Uterus Breast	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Bruce M. Towers M. D. or other
Address Catonsville Date signed 4-22

Dr. James G. Howell
715 Frederick Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

1521 P

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years, 5 months

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 25 years, 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1122 William Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Albert Stauffer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 5, 1878

8. AGE: Years	Months	Days	If less than one day
68	7	11	..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Factory

FATHER
12. Name: John Stauffer
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Vogel
15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-5-1947 (month) (day) (year)

Cemetery or crematory: Holy Cross Ritchie Highway

Location: Ritchie Highway & C & O

18. Funeral director: Elizabeth Wade Inc.

Address: 116 E. West St. Balto. Md.

19. 5/3 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947 at 8:00 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1922 to April 16 1947 and that I last saw him alive on April 16 1947

Immediate cause of death	DURATION
Coronary thrombosis	minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did Injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Isadore Tuark, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed 5-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

Dr. C. F. Hudson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

66802

Reg. Diat. No.

1. PLACE OF DEATH:
County Glen Arm,
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Glen Arm, P.O. Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Glen Arm
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Glen Arm, P.O. Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry C. Stengel, Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Katherine Inez Stengel
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1893

8. AGE: Years	Months	Days	If less than one day
53	9	6	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Casper E. Stengel
13. Birthplace Md.

MOTHER
14. Maiden name Mary E. Fortman
15. Birthplace Md.

16. Informant Mrs. K. Inez Stengel
Address Glen Arm. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/47 (month) (day) (year)
Cemetery or crematory St John's Cem.
Location Long Green, Md.
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road
19. 5-2 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1946, to April 30 1947
and that I last saw him alive on April 28, 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	6 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gilford F. Hudson M.D.
M. D. or other
Address Fork Md Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

06803

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town Joppa Rd. Ridgewood Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Joppa Rd.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ridgewood, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war. None

3.(a) FULL NAME William H. Sterrett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	colored	widowed

6.(b) Name of husband or wife Jeanette Sterrett (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1861

8. AGE:

Years	Months	Days	If less than one day
86?			..... hrs. ..... min.

9. Birthplace Glenarm, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name not known
13. Birthplace —
MOTHER 14. Maiden name not known
15. Birthplace
16. Informant Joshua Sterrett
Address Joppa Rd. Ridgewood, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof 4/15/47 (month) (day) (year)
Cemetery or crematory St Luke's
Location Sanford, Md.
19. Funeral director William J Blakeman Jr
Address 1701 ME. Cullot St. Balto. Md.
19. April 16 1947 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940 to April 15th 1947 and that I last saw h.m. alive on Apr 11th 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	
Due to General Arteriosclerosis	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Daniel J. or S. Thos. Jones M. D. or other
Address ..... Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00804 B

Reg. Dist. No. 438

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since October 19, 1946

Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since October 19, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Florida County:

City or town: Miami Beach (If outside city or town limits, write RURAL and give nearest town)

Street No. 1615 Pennsylvania ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Charles T. Street

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 17, 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	11			

8. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Retired leather goods Baltimore

11. Industry or business:

FATHER — 12. Name: Charles Street

13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Anna Osborn

15. Birthplace: Baltimore Md

16. Informant: Personal History- Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/47 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: Baltimore Md.

18. Funeral director: H. H. Mears and Son

Address: 805 N. Calvert St

19. 4/19 1947 (Date rec'd by registrar) T. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1947, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 1946, to April 18 1947

and that I last saw him alive on April 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	about June 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 4-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

00805

Reg. Diat. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:
Belair Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearcat town)

Street No. Belair Rd. Nr. Gunpowder Falls
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Grace R. Stricklin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John Stricklin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 3rd, 1881

8. AGE: Years	Months	Days	If less than one day
66	3	14	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Parken Kerr

13. Birthplace: Carroll County, Maryland

MOTHER 14. Maiden name: Mary S. Gosnell

15. Birthplace

16. Informant: Mr. Ernest Stricklin
Address: Belair Rd. Fullerton P.O.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/21/47 (month) (day) (year)

Cemetery or crematory: Perry Hall Methodist

Location: Perry Hall, Maryland

18. Funeral director: Lasacha Funeral Home

Address: 1401 Belair Road.

19. 4/19/47 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17th 19 47 at 10:40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 9 19 43, to April 17 19 47

and that I last saw h[illegible] alive on April 17, 19 47

Immediate cause of death	DURATION
Congestive Heart failure	3 Mos.
Due to Coronary Sclerosis	4 yrs.
Heart Disease	
Due to	
Other conditions Cholelithiasis with Emphysema and Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Cholecystectomy

Date of op. 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Clifford A. Anderson M.D.

M. D. or other

Address: Fork Md. Date signed 4/18/47

VS/A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

00806 42
Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
35 Elizabeth Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 35 Elizabeth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM PRESTON STUNZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret E. Stunz (nee Wade)
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 19, 1882

8. AGE: Years	Months	Days	If less than one day
64	9	1	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: -

11. Industry or business

FATHER
12. Name: Herman P. Stunz
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Anrina Dittacher
15. Birthplace: Cincinnati, Ohio

16. Informant: Mrs. Margaret E. Stunz
Address: 35 Elizabeth Ave., Lansdowne 27, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 4/21/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1947 at 3:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1947, to April 20 1947 and that I last saw him alive on April 20 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Arthur Roxburgh M.D.
M. D. or other
Address: 2411 Washington Blvd. Date signed: 4/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-41

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

00807

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 2 mos., 8 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 2 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1609 N. Wolfe Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. William E. Sturm

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Mary Sturm

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) December 11, 1885

8. AGE: Years	Months	Days	If less than one day
61	4	7	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Supervisor - Water Dept.

11. Industry or business

FATHER 12. Name William E. Sturm

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Catherine Kaltenback

15. Birthplace Baltimore, Maryland

16. Informant Mrs. Margaret Raynor, Daughter

Address 1840 N. Chapel St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23, 1947 (month) (day) (year)

Cemetery or crematory Holy Redeemer Cemetery

Location 4430 Belair Rd., Baltimore, Md.

18. Funeral director H. Sandor & Sons, Inc.

Address North Ave., & Broadway, Balto., Md.

19. April 18, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947 at 11:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1947, to April 18, 1947 and that I last saw him alive on April 18, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr. 4 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Chronic Myocardial & Valvular Tuberculous Laryngitis (Include pregnancy within 3 months of death)	Unknown 4 Mos.

Major findings of operation: No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. F. Siegel M.D. M. D. or other

Address Mount Wilson, Md. Date signed 4/18/47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

06808

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: 4 x 4 Delaware Ave., Essex
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County Montgomery
City or town Norristown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1411 Mullen St.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Lela Mae Thumm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widowed

6.(b) Name of husband or wife Wm. Christian Thumm
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1878

8. AGE: Years	Months	Days	If less than one day
69	1	13	..... hrs. ..... min.

9. Birthplace Norristown Pa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name Isaac P. Manning
13. Birthplace Pawling, Chester Co.
MOTHER 14. Maiden name Mary R. Markley
15. Birthplace Phoenixville, Pa.
16. Informant Mrs. Eleanor Vendetti
Address 4 x 4 Delaware Ave. Essex
17. Removal (Burial, cremation, or removal. Which?) Date thereof April 20, 1947 (month) (day) (year)
Cemetery or crematory Riverside
Location Near Penn Drive
18. Funeral director D. Rae Bayne
Address 718 Swede St, Norristown, Pa.
19. Apr 22 1947 (Date rec'd by registrar) John H. Connelly per P.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April 1947, at 9.30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 April 1947 to 20 April 1947 and that I last saw h.e.r alive on 19 April 1947

	DURATION
Immediate cause of death Heart Failure	7 days
complicated by virus	
Pneumonia	
Due to Chr. Myocarditis	years
Due to Asbestosis?	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Maxwell Edmund M.D. M. D. or other
Address 4, 7 1/2 Eastern Ave. Essex Date signed 4-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-d)

CERTIFICATE OF DEATH

00809 Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 435 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 435 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 E/ 20th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JOHN E. TILLMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-25-96

8. AGE: Years	Months	Days	If less than one day
50	7	12	hrs. min.

8. Birthplace: Harford Co., Maryland (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11, 1947 (month) (day) (year)
Cemetery or crematory: Balto. National Cemetery
Location:

18. Funeral director: Mrs. Robt. A. Elliott & Daughter
Address: 1129 N. Caroline St.

19. April 10 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 19 47 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 19 46 to April 7 19 47 and that I last saw him alive on April 7 19 47

Immediate cause of death: Right Cerebellar lobe tumor — DURATION: Unknown

Due to: Nature of tumor undetermined, at this time, as microscopic studies have not been completed. C.M.O.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIRECTOR
Address: V.A.H. FT. HOWARD, MD. Date signed: 4-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58)

CERTIFICATE OF DEATH

00810 P

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years 5 months 13 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 12 years, 5 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryoand County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Irene Maybelle Timanus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stanley Bruce Timanus
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	7	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: William Nicholson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Widerman
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Catonsville, 28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet, Cem.
Location: Randallstown, Md.
18. Funeral director: Theo. Lamoreaux
Address: 4510 Liberty Hgts Ave

19. April 28 1947 (Date rec'd by registrar) R. W. Hedrick Registrar
85

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 1947 19 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1934 19 to April 25 1947 and that I last saw h... or alive on April 25, 1947 19

Immediate cause of death	Carcinoma of the breast bilateral, with metastases	DURATION: more than 18 months
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: left mastectomy, simple; remova... small tumor mass from right breast - 9/28/45
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk M. D. (M. D. or other)
Address: Catonsville, 28, Md. Date signed: 4/25/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

06811

Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Balto
City or town White Marsh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town White Marsh
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #40
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Brown Timmons

3.(b) Social Security Number 212-16-8890

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife Margaret (Dunn)
6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb. 27 1894

8. AGE: Years 53 | Months 1 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace Hartford Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Timmons
13. Birthplace Md.

MOTHER 14. Maiden name Alice Bramble
15. Birthplace Md.

16. Informant Mrs. Gladys Miles
Address New Cut-off & Golden Ring Rds.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-18-47 (month) (day) (year)
Cemetery or crematory Cokesbury
Location Catonsville, Md.

18. Funeral director W. K. McComas & Son
Address Catonsville, Md.

19. Apr 18 1947 (Date rec'd by registrar) John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
Address Date signed 4/15/47

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00812 P

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
60 Burkleigh Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 Burkleigh Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Katherine M. Twilley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Dr. Charles R. Twilley
6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	14	hrs. min.

9. Birthplace Elkton Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James Merritt
13. Birthplace
MOTHER 14. Maiden name Johanna White
15. Birthplace Ireland
16. Informant Merritt Twilley
Address 3812 Beech Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/9/47 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville, Md.
18. Funeral director Martin Fahey & Sons
Address 1827 W. North Ave.
19. April 8 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 1.30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-1-1943, to 4-6-1947 and that I last saw h. alive on 4-6-1947

Immediate cause of death	DURATION
Chronic Congestive heart.	2 days.
Due to, Fracture. Myocardial degeneration	3 mos.
Due to, Cerebral Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard F. Warner M. D. or other
Address 2604 Garrison Blvd Date signed 4-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-C)

CERTIFICATE OF DEATH

00813 P

4 X

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Govdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 yrs.
Hospital, Institution, or street address where death occurred: 1211 Chesaco Ave.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County —
City or town Govdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1211 Chesaco Ave
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME John W. Ullrich — **3.(b) Social Security Number** .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Emma A.

7. Birth date of deceased (mo., day, yr.) Dec 20, 1874 — B.(c) If alive, give age ..... years

8. AGE. Years	Months	Days	If less than one day
72	3	14	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Retired
11. Industry or business ?

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden name ?
15. Birthplace Germany

16. Informant Mrs Emma A Ullrich
Address 1211 Chesaco Ave

17. Burial — Date thereof April 8, 1947 (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory Emmanuel
Location Linden Lawn

18. Funeral director L. Heemann & Son
Address 6067 Harford Ave.

19. 4-7-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947 at 9 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8, 1947, to April 4 1947
and that I last saw him alive on April 4 1947

Immediate cause of death	DURATION
Toxic absorption	2 days.
Due to Bronchogenic Carcinoma	2 yrs.?
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Michael J. Dausch M.D.
M. D. or other
Address 1 W. Overlea Ave. Date signed 4-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52b

00814 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Vets. Admin. Hosp. Fort Howard, Maryland
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1912 W. Lanvale
(If rural, give LOCATION)
2.(a) If veteran, name war WW I

3.(a) FULL NAME MASON L. WALLACE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marie Wallace
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 4-3-1897

8. AGE: Years	Months	Days	If less than one day
50	0	16	hrs. min.

9. Birthplace Deal Island, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Thomas Wallace
13. Birthplace Deal Island, Maryland

MOTHER
14. Maiden name Annie Causey
15. Birthplace Deal Island, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22-1947 (month) (day) (year)
Maryland Memorial Cemetery
Cemetery or crematory
Location Baltimore, Md.

18. Funeral director Ellsworth Armacost
Address 3911 Liberty Heights Avenue

19. 4/21 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 19 47 at 9:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 47 to April 19 19 47 and that I last saw him alive on April 19 19 47

Immediate cause of death	DURATION
Papillary adenocarcinoma of the bladder	3 years
Due to	
Due to	
Other conditions Secondary anemia	3 years

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jacob Katz a/B
JACOB KATZ, M.D. M. D. or other
Address VAH, FORT HOWARD, MARYLAND Date signed 4/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give street address or location and age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

CERTIFICATE OF DEATH

00815

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Bellona Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bellona Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: CHARLES VINSON WALTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine J. Fenwick

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): November 3, 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	5	3		

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Automobile Mechanic

11. Industry or business: Brooks-Price Co., Balto., Md.

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Katherine J. Walton
Address: Bellona Ave., Lutherville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8, 1947 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery

Location: Towson, Maryland

18. Funeral director: John Burns Sons

Address: Towson, Maryland

19. Apr. 8, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 6 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 2 1947 to April 6 1947 and that I last saw him alive on Apr. 6 1947

Immediate cause of death	DURATION
Terminal Pneumonia, Bron	4 Days
Due to Paraplegia.	Nov 1946
Due to Hypertension.	unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Bennett A. Stearn M. D. or other

Address: Lutherville, Md. Date signed: 4/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52a)

00816

CERTIFICATE OF DEATH

Reg. Dist. No. 40

Typewrite or print. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Hyde, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Letta A. Ward

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Robert Dickey Ward
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 16, 1883

8. AGE:

Years	Months	Days	If less than one day
63	4	19	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Philip Beatty
13. Birthplace: Maryland
MOTHER 14. Maiden name: Catherine Ryan
15. Birthplace: Maryland
16. Informant: Robert D. Ward
Address: Hyde Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8 1947 (month) (day) (year)
Cemetery or crematory: Long Green
Location: Long Green Md
18. Funeral director: Kaufelgent & Sons
Address: Benson Md.
19. April 8 1947 (Date rec'd by registrar) C. E. Arthur Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1, 1946 to April 5 1947
and that I last saw h[illegible] alive on April 5 1947

Immediate cause of death	DURATION
Hypernephroma Kidney (left)	7 MOS.
Due to	
Due to	
Other conditions: Hypertension Cardiovascular Disease	7 YRS.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D.
M. D. or other
Address: Fork, Md Date signed 4/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

06817

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Curtis Ernest Weikert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	M

6.(b) Name of husband or wife: Lillian E. Weikert

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 13th, 1876

8. AGE:	Years	Months	Days	If less than one day
	70	6	7	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Home Construction

FATHER
12. Name: Curtis E. Weikert
13. Birthplace: Germany

MOTHER
14. Maiden name: Caroline Ernestine Sack
15. Birthplace: Germany

16. Informant: Mr. Charles Curtis Weikert
Address: Ridge Rd. #474 Balto. 6, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/23/47 (month) (day) (year)

Cemetery or crematory: Moreland

Location: Taylor Ave.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road.

19. Apr. 20 19 47 (Date rec'd by registrar) Ma. G.L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 April 19 47 at 12 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to 20 April 19 47 and that I last saw h.. alive on 18 April 19 47

	DURATION
Immediate cause of death: Cerebral hemorrhage	3 months
Due to: Hypertensive C-V disease	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A L Kolodny M.D. M.D. or other

Address: 45 Edgevale Baltimore 2, Md. Date signed 20 April 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B 00815 — Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since March 18, 1947
Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since March 18, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: District of Columbia — County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 1419 35th St NW (If rural, give LOCATION)
2.(a) If veteran, name war: First World War — 1917 ✓

3.(a) FULL NAME: T Frank Welch — **3.(b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Josie Welch — 6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): October 12, 1898

8. AGE: Years: 48 — Months: 5 — Days: — If less than one day: ... hrs. ... min.

9. Birthplace: Washington D C (Town, county, and state)

10. Usual occupation: Physician

11. Industry or business:

FATHER — 12. Name: Douglas Welch — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Kate Walsh — 15. Birthplace: District of Columbia

16. Informant: Personal History-Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) — Date thereof: Apr 8, 1947 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemetery
Location: Washington, D.C.

18. Funeral director: Thomas B Hanlon
Address: 641 D St N.E. Washington D.C.

19. Apr 5 1947 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1947, at 2:17 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1947 to April 5 1947 and that I last saw him alive on April 4th 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Since August or Sept 1946

Due to:

Due to:

Other conditions: Bronchitis + Bronchiectasis for 20 years — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

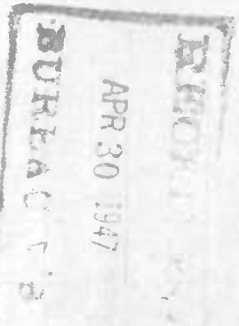
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: W A Bridges — M. D. or other
Address: Towson 4, Maryland — Date signed: 4-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 M



VS A15 9-4 M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

06819

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Balto.

City or town: Woodlawn ~~Cem.~~

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Virginia & Pembroke Aves.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Woodlawn ~~Cem.~~

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Virginia & Pembroke Aves.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES EDWIN WHITE

3.(b) Social Security Number: 215-05-5376

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna E. White

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1883

8. AGE: Years	Months	Days	If less than one day
63	7	22	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Traffic Mgr.

11. Industry or business: Armour & Co.

FATHER

12. Name: William I. White

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden name: Susan ~~Bentley~~ Bentley

15. Birthplace: Va.

16. Informant: Mrs. Charles R. White

Address: Virginia & Pembroke Aves.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/26/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 4/25 (Date rec'd by registrar) 19 47 A. W. Helmick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 12 19 47 to Apr 24 19 47

and that I last saw him alive on Apr 14 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to Arteriosclerosis	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: A. C. Lamb M. D. or other

Address: 4209 Gibson Ave. Date signed: Apr 25

00820

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 5 months, 8 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 5 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore City Hospitals
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Whitnack

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife: Harriet Weterell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 29, 1858

8. AGE: Years	Months	Days	If less than one day
89	1	19	hrs. min.

9. Birthplace: Maine
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Unknown

FATHER
12. Name: William Whitnock
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Maria Davidson
15. Birthplace: Maine

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-7-47 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Md.

19. 5-7 19 47 Harriet Weterell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 19 47 at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 19 44 to April 17 19 47 and that I last saw him alive on April 17 19 47

Immediate cause of death	DURATION
Left subdural hemorrhage	indefinite
Broncho pneumonia	5 days
Due to Extensive generalized arteriosclerosis with myocardial insufficiency and	
Due to chronic cardiovascular-renal disease	indefinite
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 5-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00821

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 5 mos., 7 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yr., 5 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Bloomsbury Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Hilda M. Williams

3. (b) Social Security Number: No. Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert F. Williams
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): October 5, 1925

8. AGE: Years	Months	Days	If less than one day
21	6	19	...hrs. ...min.

9. Birthplace: Frederick Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Howard T. Grimes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Eyre
15. Birthplace: Maryland

16. Informant: Mrs. Hilda M. Williams
Address: 22 Bloomsbury Ave., Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26, 1947 (month) (day) (year)
Cemetery or crematory: McKendree Church Cem.
Location: Howard Co., Maryland

18. Funeral director: Easton and Sons
Address: Ellicott City, Maryland

19. April 24, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1947 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1945 to April 24, 1947 and that I last saw her alive on April 24, 1947 1947

Immediate cause of death	DURATION
Far Advanced Pulmonary Tuberculosis	2 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	3 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. I. Siegel M.D. M. D. or other
Address: Mount Wilson, Md. Date signed: 4/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93)

00822

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Balto.

City or town Essex 21

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Essex 21 Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 627 Franklin Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR W W I

3. (a) FULL NAME Edwin Wolf.

3. (b) Social Security Number 213-07-2362

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Johanna.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 28 - 97

8. AGE: Years	Months	Days	If less than one day
50.			____ hrs. ____ min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Steel Ind.

FATHER 12. Name John Wolf.

13. Birthplace Balto Md

MOTHER 14. Maiden name Pauline Kunis

15. Birthplace Balto Md.

16. Informant Johanna Wolf

Address 627 Franklin Ave.

17. Burial Date thereof April 14-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Paul. Taft Emg.

Location Cardiff St Balto Md

18. Funeral director Buzdzenske

Address 1467 Eastern Ave Rd.

19. April 14 19 47 A. W. Hedrick

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 47, at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1946, to April 1947, and that I last saw him alive on April 11 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hours
Due to Hypertensive Cardio-vascular disease.	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Miceli M.D.

M. D. or other

Address 7601 Eastern Ave Date signed 4/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94a)

Reg. Dist. No. 00823 44

CERTIFICATE OF DEATH

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

(a) County Balto

(b) City or town White Marsh (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Route #40 Near Ebenezer Rd

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County B

(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3620 Fairview one. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Morris Woloshin.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jean

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1688

8. AGE: Years 59 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Red Hayden Co.

FATHER 12. Name Benjamin Woloshine

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Gartman

15. Birthplace Russia

16 (a) Informant Mrs Jean Woloshin

(b) Address 40?. Fairview Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Apr 5-47 (month) (day) (year)

(c) Cemetery or crematory New York

Location New York

18 (a) Funeral director John B Connolly

(b) Address 708 Eastern Ave

19 (a) 4/5/47 (Date rec'd by registrar) (b) John B Connolly Registrar

MEDICAL CERTIFICATION

20. Date of death April 4 1947, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 4 19__, to Apr 4 1947, and that I last saw him alive on ____ 19__.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J M Learmont M.D. M. D. or other

Address Deputy medical Examiner Dundalk, Md. Date signed 4/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00824

131 D

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred: 8110 Harford Rd

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8110 Harford Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eugene Wuerz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Emelia

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): May 21 1869

8. AGE: Years: 77 Months: 10 Days: 16 If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: a. ~~Housewife~~ Carpenter

MOTHER FATHER

12. Name: ?

13. Birthplace

MOTHER

14. Maiden name: ?

15. Birthplace ?

16. Informant: Mrs. Emelia Wuerz

Address: 8110 Harford Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 9 1947 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Taylor Ave -

18. Funeral director: [illegible]

Address: 5305 Harford Rd

19. April 8 1947 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1947, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1943, to April 6 1947 and that I last saw h[illegible] alive on April 3 1947

Immediate cause of death	DURATION
(a) Chr. myocarditis	4 yrs +
(b) Chr. nephritis	
Due to	
Due to	
Other conditions: Paralysis agitans	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. M. Bacon M. D. or other

Address: 8110 Taylor Ave Date signed: 4/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Bacon
VS A15
8110 Taylor Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

06825 P

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn (Hebbville)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Rolling Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Woodlawn (Hebbville)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rolling Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin F. Lee Zimmerman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Harriett E. Zimmerman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 21, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	9	hrs. min.

9. Birthplace: Hebbville, Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Benjamin F. Zimmerman
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden name: Caroline Widerman
15. Birthplace: Baltimore County, Md.

16. Informant: Mrs. Lillian Watts
Address: Rolling Road, Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cemetery
Location: Randallstown, Md.
18. Funeral director: Miles Lawrence
Address: 4510 Liberty Heights Ave.

19. May 2 1947 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1947, at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A-29 1947 to A-29 1947 and that I last saw him alive on A-29 1947

Immediate cause of death	DURATION
Chronic Nephritis	
Due to: Generalized Arteriosclerosis	
Due to: Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos J Ellis M. D. or other
Address: 4509 Liberty Heights Ave. Date signed

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

00826

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 9 mths. 10 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 9 yrs. 9 mths 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 613 S. Streeper Street
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: Fannie Zitzer

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Herbert E. Zitzer

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): About 1888, August

8. AGE: Years	Months	Days	If less than one day
58	?	?,	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: George W. Dix
13. Birthplace: unknown

MOTHER
14. Maiden name: Betty Kelly
15. Birthplace: unknown

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-21-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Ritchie Highway

18. Funeral director: Lilly & Zeiler Inc.

Address: 403 S. Wolfe St. (31)

19. 4/21 (Date rec'd by registrar) 47 A. K. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18, 19 47 at 8:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 19 37, to April 18 19 47 and that I last saw her alive on April 18, 19 47

Immediate cause of death	DURATION
Bronchopneumonia, left base	14 hours
Due to: Chronic arteriosclerotic cardio-	
Due to: renal vascular disease	indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: --

Accident, suicide, or homicide. Date of?

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Spring Grove St. Hosp. Catonsville, Md. Date signed 4-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45